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**Mainstreaming complementary therapies into
primary care: the role of evidence, 'ideal' service
design and delivery and alterations in clinical
practice**

Lesley Wye

A dissertation submitted to the University of Bristol in accordance with the
requirements of the degree of Doctor of Philosophy in the Faculty of
Dentistry and Medicine, the Academic Unit of Primary Health Care, the
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Abstract

This thesis explores a range of issues around the mainstreaming of complementary therapies delivered by professional therapists into the NHS. The thesis question is: how does the complementary therapy community need to adapt to be mainstreamed into NHS primary care? To answer this, I explored the role of evidence, service delivery and design and variations in clinical practice in private and NHS settings.

Using predominately case study methodology, data were collected at two NHS sites hosting complementary therapy services including:

- Interviews with Primary Care Trust (PCT) managers, NHS clinicians and staff, therapists and patients (n=34).
- Observations of acupuncture and homeopathy consultations (n=22)
- Documentation (e.g. evaluations, referral databases, meeting minutes and funding bids)

Atlas-ti computer software assisted in handling data. Data were analysed in a variety of ways including: quantifying activities (observations of consultations), calculating rates (referral databases), highlighting and extraction of key information (service evaluations, meeting minutes, funding bids) and thematic analysis (interviews and observation of consultations). After preliminary analysis, data from all sources were compared and contrasted using a constant comparative method to elaborate findings and identify discrepancies.

To attain mainstream status, multiple shifts would be required. This would include the creation of a widespread perception of clinical evidence of therapeutic effectiveness to persuade NHS professionals that complementary therapies 'work'. In addition, complementary therapy service evaluations, which include NHS cost data (ideally with impact on secondary care referrals), would be required, although these evaluations may not feed into the decision making process for NHS funding.

Furthermore, NHS acceptable complementary therapy service structures would need to be established with specific treatments for medically defined conditions that are currently not well treated by biomedical interventions. These would need to be targeted to high priority groups without expanding the boundaries of the NHS by picking up unmet need. In addition, these services would have to be championed by well-respected clinicians (preferably doctors) with strategic commissioning roles. Such services may be more fortuitously located in local health systems that emphasise patient-centred care.

Once a complementary therapy service was established, service providers would need to build collegial relationships with biomedical colleagues to create the perception that both biomedical and complementary therapy practitioners were working under the same healthcare umbrella. One way of achieving this is by opening complementary therapy consultations to observation by biomedical professionals.

However, many of the required alterations identified in this study conflict with each other and with the philosophies, principles and approaches of complementary therapies. Furthermore, application of change management models suggests that neither the innovation (complementary therapies) nor the actors (the NHS and

complementary therapy communities) nor the environment (the NHS) are ready. Therefore, the widespread mainstreaming of complementary therapies within the current context of the NHS is understandably frustrated.

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This thesis is dedicated to Xius.

I declare that the work in this dissertation was carried out in accordance with the Regulations of the University of Bristol. The work is original, except where indicated by special reference in the text, and no part of the dissertation has been submitted for any other academic award. Any views expressed in the dissertation are those of the author.

Signed: Hesley Wip

Date: 16.5.8

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CHAPTER 1 Introduction

1.1 Alice's story

This thesis is about the mainstreaming of complementary therapies into the National Health Service (NHS) in the United Kingdom (UK). Throughout the following chapters, multiple perspectives will be heard including those of commissioners, doctors, nurses and complementary therapy service providers. But patients' (or clients') voices are largely missing. This is not an accidental oversight but deliberate, since the central question of this thesis is the adaptations necessary for complementary therapies to fit into the NHS. Thus, the focus is on the exigencies of NHS professionals and the response from the complementary therapy community to them.

Notwithstanding, patients are pivotal to the likelihood of complementary therapies becoming mainstreamed. Moreover, while individual professionals from each camp ignore, vilify or cautiously approach each other, clients often integrate diverse types of healthcare with few difficulties. Thus, I wanted to begin this thesis by grounding it in the story of one such individual. This is to remind readers (and myself) that despite the complexity in bridging such different philosophies of care at organisational and professional levels, clients do so with relative ease.

I could have told the stories of several different patients from this study, but I chose that of Alice because if complementary therapies are ever to become mainstreamed, she is likely to benefit. Alice is 41 years old. Married at 21, she is now divorced and has three children who are aged 16, 14 and 11. Currently, Alice works as a cleaner for two businesses. For seventeen years, Alice has lived in the same relatively deprived inner city area.

Alice's health problems started with her final pregnancy. During the pregnancy, she experienced acid reflux, which disappeared at the birth and then reappeared more persistently five years later. Alice also suffered from recurrent Caesarean scar infections. The itchiness from the wound often spread from the scar to the skin on her entire body. To remedy this, she would apply an antibiotic cream and bathe in ster-zac. She had been going to the doctors for repeat prescriptions for antibiotic cream about

once a month for four years. In addition to the acid reflux and the recurrent wound infections, Alice did not have any sensation between her naval and her groin. After six months of repeat prescriptions of omeprazole for the acid reflux, her doctor suggested acupuncture, which was subsidised as part of a low cost complementary therapy service located in local NHS premises. At the start of her acupuncture treatment, Alice was also taking Prozac for depression.

Alice initially had a course of eight acupuncture sessions, about one every two to three weeks. As a result of those sessions, she said:

When I first started seeing [the therapist] I was on double the medication I'm on now for the acid reflux. And through seeing [the therapist], I said to my doctor, "I can take my capsule every other day, 30 milligrams." And she said, "How long have you been doing that?" And I said, "Oh, for about a month." She said, "Right, we'll cut your medication down and let me know if there is any difference." In the meantime, I was able to come off the Prozac I was on; the acupuncture helped that as well. And then I went back to my doctor and said, "I can take 10 milligrams every other day now as well." It's almost as if because I'm having the treatment on my stomach, it's helping so I have to take less medication. The scar also, where it used to be red and sore all the time, it's not. It's not. And I said to [the therapist] yesterday, "I feel now as if when you got your knickers on, your belly don't (sic) seem so wobbly." I said, "When I take my knickers off, it still feels like I've got them on because my belly skin is actually tightening and the muscles are beginning to work." So I said to her, "I can really, really feel the difference." (Patient, A, line 97)

Nonetheless, Alice still required biomedical treatment. She had an operation to revise the Caesarean scar. After the operation, Alice stopped acupuncture treatments and found that she gradually increased her dose of omeprazole and her weight crept up. Nine months from the operation, she restarted acupuncture treatments. She attends a drop-in acupuncture clinic located at her doctors' surgery. Alice is also on a waiting list for an operation to remove gallstones.

Alice thinks that the "benefits are brilliant" in having access to acupuncture at her local GP surgery and using the two approaches in parallel. Given that many amongst the medical and complementary therapy communities are less convinced, the purpose of this thesis is to explore what changes are required, if this relatively rare approach is to become more commonplace.

1.2 PhD overview

To explore this, I am primarily interested in the adaptations necessary for the obtaining of mainstream status in primary care. “Primary care” encompasses general practice surgeries and community clinics, both funded currently by Primary Care Trusts (PCTs). I have excluded from this enquiry services operating in secondary care for two principal reasons. First, historically during “boom times”, primary care sectors are where complementary therapy services tend to proliferate and are the most likely point of mainstreaming (Thomas *et al.* 2001b). Secondly, I work in a Primary Health Care unit and therefore wanted to study a primary care based topic.

Furthermore, for the purposes of this study, the focus is on state or charitable funded services located in NHS primary care settings in which a complete package of complementary therapy care is delivered, usually by “professional” or “lay” complementary therapists. Trained in one or more modalities by complementary medicine colleges and affiliated institutions, these healthcare practitioners tend not to have biomedical backgrounds. Doctors or other NHS professionals, who have added complementary therapy techniques to their “conventional armoury” (Adams, 2000; Thompson, 2005), but continue practising within a biomedical model, are excluded. This is because this thesis aims to explore how different paradigms of health co-exist at organisational rather than individual, personal levels. However, therapists with biomedical backgrounds, who operate entirely within holistic complementary therapy paradigms (see 2.2.1 for full definition) are included.

1.2.1 Research questions and structure of the thesis

The primary research question for this thesis is: How does the complementary therapy community need to adapt to be mainstreamed into NHS primary care?

Initially, I also asked the reverse question: how does the NHS community need to adapt to mainstream complementary therapies? But for reasons presented later (see 3.5.1.3), this question was eliminated.

To clarify, by “complementary therapy community” I mean practitioners, their professional bodies, complementary therapy service designers, proponents of mainstreaming, evaluators of complementary therapy services, complementary therapy

researchers and even the underpinning philosophies of the therapies themselves. I am referring to the complementary therapy community in its widest possible sense. Having clarified the focus and terms of this study, I will now continue by discussing its structure and sub-questions.

In this thesis, issues are explored at three levels: macro, meso and micro. Although this approach might appear complicated, Vaughan argues that varying the units of analysis from macro to meso to micro “can generate startling contrasts that transform our theoretical constructs” (Vaughan, 1992). In addition, this multi-layered approach more closely mirrors the values and philosophies of complementary therapies, with their emphasis on ‘holism’ and interconnectedness. Furthermore, the thesis question cannot be satisfactorily answered by only focusing on one level. The aim of all three is the same – to explore the alterations required for mainstream acceptance.

If the three are positioned as vertical silos, the macro focuses on the role of evidence, the meso on complementary therapy service design and the micro on differences in clinical practice in NHS and private settings. All three address the primary research question and have a sub-research question of their own. They are:

- Macro - Evidence

What role do clinical evidence and service evaluations play in mainstreaming complementary therapies?

- Meso - Service delivery

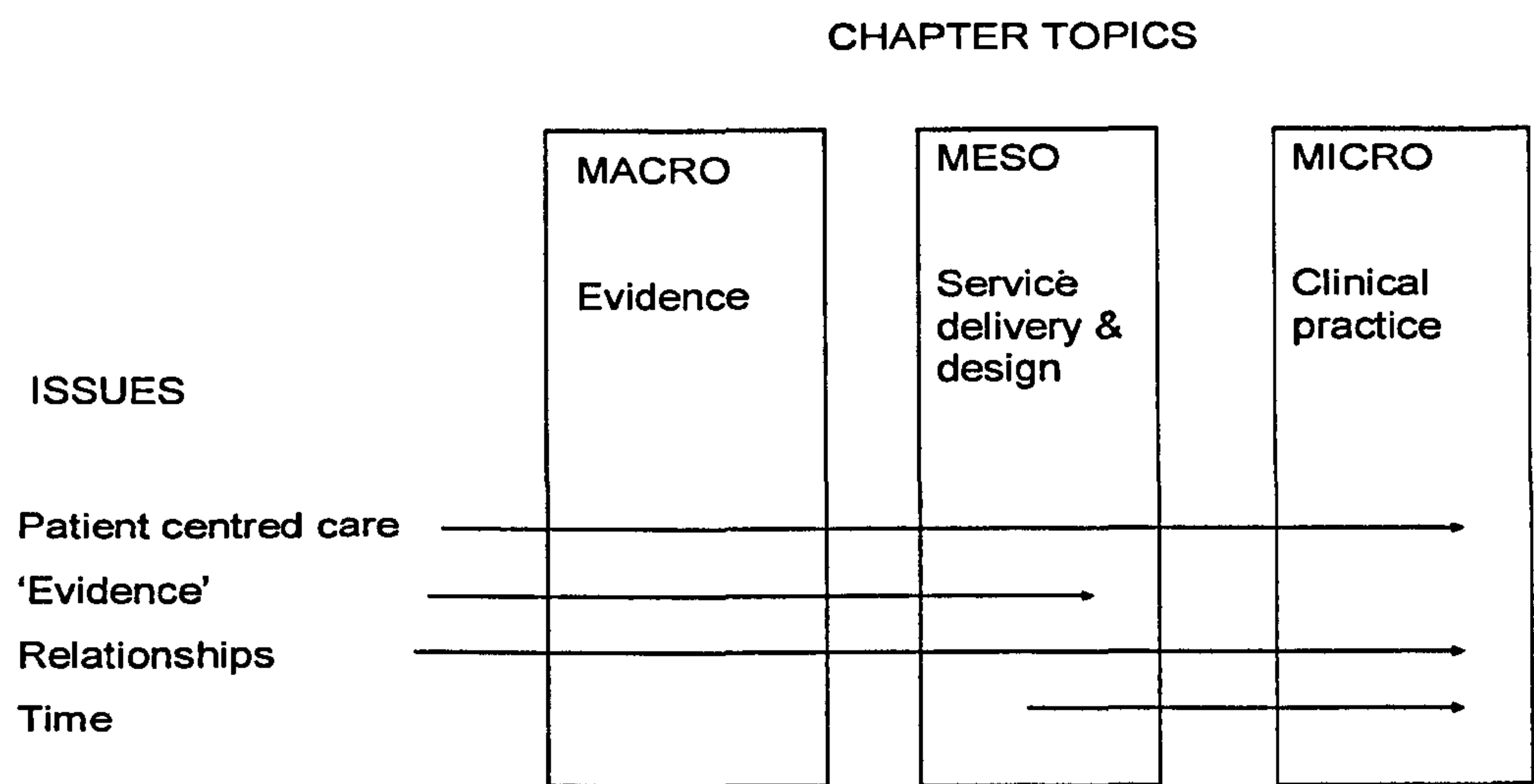
What does a ‘NHS acceptable’ complementary therapy service look like?

- Micro - Clinical practice

Are there differences between complementary therapy treatments delivered in the NHS and privately?

Each question is explored independently, while the key issues of patient centred care, inter-professional relationships, the use of evidence and time make repeated reappearances and are interwoven throughout the thesis, knitting the three topic levels together. (see Figure 1).

Figure 1 Structure of thesis



As each chapter covers a distinct level (macro, meso or micro), unlike other theses that have clearly demarcated chapters of literature, methods, results and discussion, here those distinctions blur. Hence, results chapters will include considerable literature and discussion, as well as original findings. To synthesise these, all three levels are then studied in relationship to each other in the discussion chapter. The next section provides background and rationale for the selection of the three issues at macro, meso and micro levels.

1.2.2 Three levels of this study

I have long held an interest in the nature of ‘evidence’ and its application in practice to policy and clinical decision-making. The role of evidence is a macro level topic, as regardless of where a potential NHS complementary therapy service may be located geographically, the issue of evidence poses barriers to mainstreaming. One type of evidence is service evaluations and so an aim is to analyse a broad cross section of reports to explore more fully what complementary therapy services may have to offer.

In exploring evidence, chapter four focuses on the meanings given to evidence by clinicians and PCT managers, the evidence needed to inform decision-making about complementary therapy service provision, where and how evidence is located, the importance of clinical research evidence and service evaluations in commissioning services and the tensions of evidence based healthcare and patient choice.

To understand organisational issues around mainstreaming at a meso level, I have studied complementary therapy services at two sites. Despite over a decade of debating the merits of state funding of complementary therapies, not much is known about the ways in which complementary therapy services are brought into the NHS. The little literature that does exist tends to describe actual service model design (Paterson and Peacock, 1995; Peters, 2002). In the mid 1990s, Luff and Thomas carried out a landmark UK policy study that addressed aspects of this research gap. Studying ten NHS complementary therapy services across the nation, their aim was to identify levers and barriers for service provision (Luff and Thomas, 1999; Luff and Thomas, 2000b; Luff and Thomas, 2000a). But what they did not comprehensively address was the process by which complementary therapy services are designed, nor the broader question of what features mark out complementary therapy services that are more acceptable to NHS clinicians and commissioners. These will be presented in chapter five.

The third level of this study concerns clinical practice. Very little research has been carried out into the differences between the private and state funded delivery of treatments in either biomedical or complementary therapy service settings. Whether this is due to a lack of interest or because the preponderance of funding is funnelled into the NHS is unknown (Humphrey and Russell, 2001). Of the research that has been done within the biomedical field, two studies stand out.

Observing over 1,100 private and NHS consultations in the 1970s, Strong found that organisational factors are as important as individual ones in explaining or modifying clinical behaviour (Strong, 2001), a finding that led to the inclusion of the service delivery and design aspect of this study. In the early 1980s, Silverman observed 146 consultations, delivered by an oncologist in NHS and private clinics, finding that “social” factors such as greater courtesy and a more personalised, individual service distinguished private sessions from their state funded counterparts (Silverman, 1987).

Within the complementary therapy field, Hills carried out an interview study with seven therapists working privately and in a GP surgery in the mid 1990's. Therapists identified the biggest impact on their NHS clinical practice was the time restrictions, both in terms of the length of a session and the total number of sessions permitted. Therapists also had to adapt to NHS premises, which were more utilitarian and less flexible than private settings (Hills, 2005). The other key study in this area in complementary therapies was carried out by Barry. Observing both a professional homeopath and a GP homeopath, she noted that time was an important factor. The GP homeopath attempted to treat patients within the prescriptive ten minute consultation and as a result confused his patients with insufficient information and annoyed his partners since his surgery always finished late. The professional homeopath was relaxed with a "reverent respect and almost religious awe for homeopathy" (Barry, 2003).

In some of these studies, the same practitioner was studied in different settings (Silverman, 1987 & Hills, 2005) while in the others, different practitioners were observed in different settings (Strong, 2001 & Barry, 2003). As a whole, these studies found key variations in usage of time, practitioner – patient relationships and practitioner identity. A striking theme running through these studies is *where* healthcare is delivered seems to affect *how* it is delivered. An aim of the third level in this thesis is to explore further in what ways and whether these modifications compromise the therapy provision unduly.

~1.3 Conclusion

Having grounded the thesis in a patient story and provided an overview of the thesis as a whole, the next chapter discusses the historical and current context of the mainstreaming of complementary therapies and reviews the literature.

CHAPTER 2 Definitions, context and literature review

2.1 Introduction

This chapter covers the historical and current context for this study. It begins with a short section on definitions and continues with an overview of complementary therapies including user characteristics, spending on complementary therapies, points of access and models of “integration” of complementary therapy services. I will then discuss the historical dominance of biomedicine since the mid 19th century and the consequent marginalisation of non-biomedical approaches in Western societies. The final section identifies and discusses some of the individuals and organisations driving (or derailing) the mainstreaming agenda.

2.2 Definitions

2.2.1 Definitions of complementary and alternative therapies

In general, there is discomfort with the lexicon of complementary and alternative therapies (Andrews and Kingsbury, 2007). Is “complementary” a better term because it de-emphasises the rivalry between complementary therapies and mainstream medicine and stresses their potential compatibility? Or should we use the term “alternative” to stress that complementary therapies offer a different understanding of health and illness? (Barry, 2003) What about integrated or integrative? (Caspi, 2001; Rees and Weil, 2001; Bell *et al.* 2002; Easthope, 2003) Unorthodox or unconventional? How about ‘non-complementary’ medicine? Should we call it biomedicine? Western Medicine? Conventional? Orthodox?

These choices are significant as they illustrate the speaker’s understanding of the rightful place of complementary therapies, be it a legitimate healthcare system in its own right, a temporary expedient or marginalised ‘quackery’. Personally, I tend to use the term “complementary therapies”, because although I believe that they offer alternatives to the medical model, and in some cases can replace biomedical treatments, it is the extent to which the two paradigms are indeed ‘complementary’ that this thesis explores. I do not use the term “CAM”, as this term is used primarily by the medical

and academic community and is a term largely unknown within the ‘rank and file’ of the British complementary therapy community. However, I do use the term ‘biomedicine’ to highlight that the current dominant paradigm is just that – another system of healthcare, albeit a powerful cosmology, but not the only one. Despite these beliefs, I approached this study undecided as to whether complementary therapies should, or indeed could, be adopted into mainstream NHS care. This ambivalence creates a tension throughout the thesis, as readers may erroneously infer from my obvious pro-complementary stance that I aim for the prize of legitimisation within the NHS. In fact, a key motivator for undertaking this study was to explore my own doubts.

By complementary therapies, I am referring to those modalities that operate within a different paradigm of health from the biomedical model. I dislike using a negative definition, but this is relatively common. For example, the House of Lords defines complementary therapies as:

...a diverse group of health-related therapies and disciplines which are not considered to be a part of mainstream medical care (House of Lords, 2000).

In this report, the Committee categorised the many complementary therapies available in the United Kingdom (UK) into three groups. Complementary therapies broadly expected to be the most likely candidates for mainstreaming included the “Group 1” therapies of osteopathy, chiropractic, herbal medicine, homeopathy and acupuncture. “Group 2” therapies were those which the Committee viewed as “used to complement conventional medicine”, such as aromatherapy, the Alexander Technique, body work therapies, including massage, stress therapy, hypnotherapy, reflexology, shiatsu, meditation and healing. “Group 3” therapies were those that the Committee saw as “indifferent to the scientific principles of conventional medicine” into which they classified kinesiology, crystal healing and interestingly Traditional Chinese Medicine among others (House of Lords, 2000). Understandably, there was considerable debate amongst the complementary therapy community as to the justness of this typology (McIntyre, 2001).

Pinpointing commonalities across this broad range of therapies is not easy, with their distinct historical developments, diagnostic and treatment techniques and

understandings of disease. In 2004, Newman Turner and Wicks published a consultation paper suggesting that the following ten principles may unify these disparate traditions (Newman Turner and Wicks, 2004).

- Vitalism or a belief in the innate intelligence of the cell
- Health seen as a positive attribute and not simply the absence of disease
- Interconnection of emotional/spiritual, biochemical and structural
- Necessity of detoxification
- Stability of internal milieu is more important than the pathogen
- Homeodynamics, for example, positive role of inflammation in getting rid of illness
- “Law of Cure” or that individuals go “backwards” towards health, whereby older symptoms reappear while more recent ones retreat
- Individuality - treatments need to be tailored
- General belief in non-toxicity and non-invasiveness of interventions
- Participative - patients play an active role

Although some of these principles may influence the clinical practice of some biomedical practitioners, especially those who attempt to practise “holistic” care, taken as a group these tenets indicate a distinctly different interpretation of health and illness from biomedical models. These principles may occur to a lesser or greater degree within various complementary therapies, and within those therapies to a lesser or greater degree with individual therapists. However, generally speaking, the understanding of health underpinning complementary therapies more closely matches the World Health Organisation definition of health as “complete physical, mental and social wellbeing, not merely the absence of disease or infirmity” (World Health Organisation, 1946). Health creation, not just the eradication of disease, is an important aim.

2.2.2 Definitions of mainstreaming

The phenomenon of primary interest in this thesis concerns the incorporation of complementary therapy services into the NHS. Many call this “integration”, but I prefer the term “mainstreaming”, as there is a difference. After my first phase of fieldwork, I realised that integration as I define it - the close collaboration and team working of health professionals from different disciplines - is unrealised for many conventional practitioners, much less those working in other health paradigms. For example, health visitors often have minimal contact with general practitioners (GPs) and are not *integrated*, but both types of professionals are firmly *mainstreamed* in that their services are an integral part of the NHS. For that reason, I prefer to use the term “mainstreaming”, as do others in this field (Tovey *et al.* 2004).

Various criteria characterise a mainstreamed service including:

- Offices or consultation rooms within NHS premises
- Repeat NHS funding contracts
- Delivery by regulated and trained personnel
- NHS line management responsibility
- Adherence to clinical governance regulations and other standards
- Referral from other NHS professionals.

I will now go on to give an overview of complementary therapy user characteristics, points of access and models of integration before continuing with a discussion of the historical and current context that is pushing complementary therapies onto the political agenda.

2.3 Complementary therapies overview

2.3.1 Prevalence of use

In exploring the prevalence of use, definitions once more become problematic. In some surveys, “using complementary therapies” means seeing a practitioner. In others, it is buying over the counter products, possibly even vitamins. Furthermore,

complementary therapies may be purely defined as one to one practitioner based treatments or may include group activities such as yoga and tai chi.

Nevertheless, a common perception within Western nations is that usage of complementary therapies is rising. In the Netherlands, a survey found that visits to a practitioner more than doubled from 6.4% in 1981 to 15.7% in 1990 (Fisher and Ward, 1994). In the United States, the proportion of respondents surveyed visiting a complementary therapist increased from 36.3% to 46.3% from 1990 – 1997 (Eisenberg *et al.* 1998). In Australia, a 1993 study found that 20.3% of those surveyed had seen a practitioner (MacLennan *et al.* 1996), while several years later in 1999 and 2002, the less robust sources of Australian national media estimated use at somewhere between 57-70% (Gripper, 1999; Russell, 1999; Madden, 2002). There are some signs however that this trend may be slowing, as a recent American study comparing adult use between 1997 and 2002 found that it had reached a plateau of about 35% (Tindle *et al.* 2005).

In the UK, the picture is somewhat confusing. An early study in 1992 found that one in four respondents had visited a complementary therapist (Consumer's Association, 1992). A later, more reliable survey carried out in 1998 found that 10% of the adult population saw a practitioner annually (Thomas *et al.* 2001a). This proportion stayed constant three years later in a survey by the same researchers (Thomas *et al.* 2003b). Meanwhile, another survey carried out in 1999 found that 20% of the population had “used complementary therapies”, although this was frustratingly never defined clearly as either seeing a practitioner or buying a complementary therapy product (Ernst and White, 2000). Moreover, condition specific surveys vary, as higher use is estimated amongst those with conditions of back pain, mental health (Barnes *et al.* 2004) and some types of cancer (Ernst and Cassileth, 2000; Eng *et al.* 2003). But those that are using complementary therapies are keeping quiet about it. Studies consistently report that the majority of complementary therapy use is not disclosed to doctors (Eisenberg *et al.* 1998; Eisenberg *et al.* 2001; Thomas and Coleman, 2004).

2.3.2 Spending on complementary therapies

So despite the perception that complementary therapy use is growing, it is difficult to ascertain whether visits to complementary therapists have decreased, increased or

remained the same over the past 15 years in the UK. Instead, the widespread belief in expanding complementary therapy usage may have more to do with its increasing infiltration into many aspects of our lives. Brain Gym, a form of kinesiology, has swept the country's primary schools (Goldacre, 2006). Hairdressers may offer reflexology and aromatherapy. A Yellow Pages television advert uses chiropractors as an example of how to "let your fingers do the walking". James Martin, a contestant in the 2005 *Strictly Come Dancing* television competition, puts his back out and tells the nation that acupuncture and osteopathy have dulled the pain. In one week in early 2007, three characters from the radio series *The Archers* experienced different complementary therapies. Complementary therapies have seeped into our daily lives.

This is aided by the rampant commercialisation of complementary therapies with health food shops on every high street and the proliferation of over the counter remedies (Collyer, 2004). This is a Western world wide phenomena. For example, it is estimated that spending on complementary therapies in Australia in 1993 was about \$480 million Australian dollars (MacLennan *et al.* 1996) rising a decade later to over \$1.2 billion Australian dollars on just Chinese medicine supplements alone (Owens, 2001). In the States, a survey in 1997 estimated that \$27 billion American dollars were spent annually (Eisenberg *et al.* 1998), while another found that out-of-pocket payments for American complementary therapy users per visit were on average \$49 for nutritional advice, \$44 for acupuncture, \$33 for massage and \$23 for herbal therapies (Peytremann Bridevaux, 2004). Here in the UK, a survey estimated total annual expenditure at £450 million (Thomas *et al.* 2001a). Evidence to the House of Lords from the Royal Pharmaceutical Society stated that a Mintel Marketing report prepared in 1999 found that the largest over the counter sales of complementary therapy products were for herbal medicine (£50 million annually) with lower consumption of homeopathic products (£23 million) and aromatherapy essential oils (£20 million). Moreover, total revenue had increased by 50% since 1994 (House of Lords, 2000). We may not be "buying into" the philosophy of complementary therapies any more now than we were a decade ago; instead we may just be purchasing more of its products. In fact, some believe that the mainstreaming of complementary therapies has little to do with wellbeing, health outcomes or an alternative perspective on health, and everything to do with increasing profit (Collyer, 2004).

2.3.3 Profile of complementary therapy users

But who are these complementary therapy consumers? In looking at predictors of complementary therapy use, studies of Western societies tend to find complementary therapy users are better educated, more affluent women, aged between 25-49 with chronic health problems (Eisenberg *et al.* 1993; Eisenberg *et al.* 1998; MacLennan *et al.* 1996; Kelner and Wellman, 1997; Millar, 1997; Mitchell and Cormack, 1999a; Ni *et al.* 2002; Shmueli and Shuval, 2004; Thomas and Coleman, 2004; Nielsen *et al.* 2005). However, not all complementary therapy users fall into this group, as a study found that 35% of non-white Americans used a complementary therapy (compared to 46.2% of the total population) rising to 67% if the definition of complementary therapies included prayer (Graham *et al.* 2005). In the UK, there is also some suggestion of significant use amongst refugee communities in the Black and Ethnic Minority populations, but we know nothing about its extent nor characteristics (Naylor, 2005). Furthermore, complementary therapy use may be becoming less the preserve of the middle-aged adults. A longitudinal matched study of users and non-users in Canada (time points 1987 and 1993) found that complementary therapy users at both time points were more likely to have higher education and higher household income, but the proportion of younger users (0-29 years) rose to nearly a third of the sample (Blais, 2003b).

Reasons for turning to complementary therapies tend to fall into “push” and “pull” factors. The push factors may include dissatisfaction with conventional medicine –including a dislike of medications and communication difficulties with health professionals (Murray and Rubel, 1992; Vincent and Furnham, 1996; Furnham and Vincent, 2003). The pull factors may include an attraction to the values embodied in some therapies of personal and spiritual development (Astin, 1998) and a positive valuation of complementary medicine (Vincent and Furnham, 1996). Some theorise that complementary therapies link in well with underlying Western values of personal responsibility (Goldstein, 2003). Others suggest that as we move towards a society more focused on fitness, we naturally extend our “perfectionistic” tendencies to our bodies (Coward, 1989). Still others suggest that complementary therapy use is symptomatic of a trend towards the democratisation of decision-making within health



care (Jonas, 2003). Studies have found that once experienced, commitment to complementary therapies results from benefits from, and satisfaction with, the treatment rather than an obligation because of payment or prior belief in complementary therapies (Luff and Thomas, 2000a; Sherwood, 2000).

A consistent message within the literature, however, is that whatever the reason for initial and then continued use, complementary therapies are not replacing biomedicine. The majority of complementary therapy users continue to combine both (Thomas *et al.* 1991; Kelner and Wellman, 1997; Paterson and Britten, 1999; Long *et al.* 2001; Sharples *et al.* 2003; Thomas and Coleman, 2004; Shmueli and Shuval, 2004), despite the fears of biomedical practitioners that this is not so (see BMJ rapid responses and letters to papers or news articles on complementary medicine, especially 2001: 322(1464) and 2005: 331(7521): 856-857).

2.3.4 Accessing complementary therapies in the NHS

About 10% of complementary therapy activity takes place in the NHS (Thomas *et al.* 2001a). 'Taking place in the NHS' however, does not necessarily mean *funded* by the NHS. 'Funded by the NHS' means that Primary Care Trusts (PCTs), which evolved from Health Authorities, have taken the decision to finance the service.

However, many complementary therapy services located within NHS premises are not PCT funded. To learn more about models of complementary therapy services, I contributed to a mapping exercise conducted by Jane Wilkinson and colleagues from the University of Westminster in autumn 2003 (Wilkinson *et al.* 2004a). The exercise aimed to locate all complementary therapy services offered within NHS primary care premises in England and Wales. Although situated within secondary care, data from the Homeopathic-Hospitals were included as well, for reasons that were not explained. Medical professionals using complementary therapy techniques (usually homeopathic products or needling) within their usual ten to fifteen minute NHS consultations were excluded. I volunteered to carry out this mapping exercise for southwest England, which included the counties of Cornwall, Devon, Dorset, Wiltshire, Somerset, Gloucestershire and Avon. This led to the creation of a typology, which was a valuable first step for my research.

In conducting the survey, I rang GP surgeries where local PCT managers believed complementary therapies were offered. Once identified, I carried out a short structured questionnaire, usually with the practice manager, which included questions on therapies offered, source of funding, clinical governance arrangements and knowledge of other practices locally providing complementary therapies. I submitted all responses to the team at Westminster in December 2003. In this way, several different models of NHS provision were uncovered, which are detailed below.

2.3.4.1 Biomedical staff practicing complementary therapies

An example of a fully mainstreamed NHS service was the Bristol Homeopathic Hospital, established in the mid 19th century and funded by several PCTs. Although the five UK NHS Homeopathic Hospitals suffer from financial vicissitudes, just as any other NHS complementary therapy service (Clews, 2007), the Bristol Homeopathic Hospital has continually rolling contracts that generally are renewed annually. It was part of the local acute trust, adhering to its clinical governance guidelines and falling under its line management responsibilities. Doctors from secondary and primary care, who delivered and ran the service, received referrals from NHS professionals in secondary and primary care, where contracts are in place.

Doctors, and more commonly nurses, also offered complementary therapy interventions in some GP practices. From the late 1990's to the early years of this century, this has become increasingly more widespread across the UK (Thomas *et al.* 2003b). Of the nearly 50% of GP practices providing access to complementary therapy interventions, a study found that treatment by biomedical practitioners was offered by almost 60% of these practices (Thomas *et al.* 2003b). In the South West, I was unable to find out how many practices had biomedical practitioners using complementary therapy techniques, as this type of practitioner was specifically excluded from the mapping study.

2.3.4.2 Professional therapists delivering treatments on NHS premises

Biomedically trained staff are not alone in offering complementary therapies in GP practices. Thomas *et al.* also found that roughly 25% of GP practices nationally

“offered” provision by professional therapists (Thomas *et al.* 2003b). Extrapolating from the figures, about half of this was probably referral to therapists in private practice known to the GP or nurse, or referral to complementary therapy services in secondary care. But 12% of GP practices included a professional therapist working within the surgery (Thomas *et al.*, 2003). In exploring this type of provision in the mapping study, I found these delivery models took many different forms.

In a few exceptional cases, professional complementary therapists were funded by a PCT. These tended to be a single practitioner, usually homeopaths or osteopaths, offering a service limited to specific conditions. I found a total of seven practices operating services within this model in the South West in 2003.

Professional therapists were also employed in state funded projects paid for by regeneration monies, such as Single Regeneration Budget (SRB) or New Deal for Communities (NDC), that stemmed from the Office of the Deputy Prime Minister. These community based projects tended to offer a much broader range of therapies (including less accepted modalities such as kinesiology and reiki) for a larger spectrum of conditions. At the time of the mapping exercise (2003) within the South West, I found three projects of this type providing services for six different GP surgeries, although one rapidly became defunct.

In the mapping exercise, there were also mixed models whereby treatments were paid for by charitable donations, patient fees, “practice savings” or any combination thereof. Mixed models also covered those services that were funded partially by PCTs and other sources. The most famous example of this type in southwest England was Glastonbury Health Centre (see www.integratedhealth.org.uk), which still continues in 2007. In total, I found three services within this classification.

I found one example of therapists who offered their services in the NHS for free, although previously they had been funded by the practice through fund-holding and latterly a research grant. Interestingly, these therapists were both spiritual healers and within spiritual healing, there is a tradition of not charging for services.

But the most common delivery model for a professional therapist within the NHS was a therapist renting a room in a GP surgery or, in other words, private provision in state

funded premises. In some cases, GPs and other health professionals directly referred. In others, a complementary therapist operated within the practice, but was not endorsed by NHS clinicians. Examples of this type were hard to quantify, and in any case were excluded from the mapping study by the Westminster team, although from personal experience, I was aware they were common.

2.3.5 Models of integration in the literature

The literature on models of “integration” may help explain these findings, as there are many typologies given (Bombardieri and Easthope, 2000; Frenkel and Borkan, 2003; Giordano *et al.* 2004; Leckeridge, 2005; Boon *et al.* 2004a). For example, a detailed model characterises seven types of services on a continuum, as philosophies, structures, processes and outcomes move from “parallel practice” to “integrative”. “Parallel practice” features practitioners from both camps working completely independently. A mid-level “co-ordinated” model would be characterised by a formal administrative structure in which patient records are shared amongst practitioners working together to provide care, facilitated by a case manager. At the opposite end, an “integrative” service provides:

[an] interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care...employ[ing] an interdisciplinary team approach guided by consensus building, mutual respect, and a shared vision of health care (Boon et al. 2004a).

In another model, Kailin presented four conceptual maps:

1. Isolated integration, where complementary therapies are offered on site but there is not a close working relationship
2. Dominating integration, where “integrative medicine is seen as a subset of biomedicine”
3. Physician-provider, in which medical professionals provide complementary therapy techniques
4. Transformative integration, whereby complementary therapists and biomedical professionals are in a dynamic relationship (Kailin, 2001).

In the mapping exercise of southwest England, I found many examples of type one, as in almost all cases complementary therapists and NHS professionals worked independently with little contact with each other. I found one example of type two, and several examples of type three, including the Bristol Homeopathic Hospital. I found no examples of type four – that of transforming services into a newly dynamic relationship.

Like Kailin, others also share this vision of the potential of complementary therapies to transform (Peters, 2002; St.George, 2004). This transformation would entail countering biomedical tendencies to “dehumanise”, while “empowering patients” and “encouraging health creation” (Peters, 2002). For some, that promise resides in the restoration of a key aspect of healing, that of spirituality, which has been taken out of biomedicine (Aldridge, 2000). But Wright argues that adding complementary medicine will not stop the descent into “soulless medicine” (Wright, 2001). History suggests that he is right; when incorporating outsiders, whether professional groups such as midwives or allied health professionals or marginalised sectors of society such as women, biomedicine has tended to set the terms of acceptance, adopting those practices or sectors that fill the gaps and abandoning the rest (Achterberg, 1990; Brooke, 2003; Saks, 2003a). In turn, the integrative behaviours of a minority group are to fill an uninhabited niche, taking nothing away that belongs to the dominant class and being careful to appease every step of the way (Achterberg, 1990). This does not sound like a recipe for transforming the NHS, much less a blueprint for infusing our current medical system with more spiritual, patient centred values. Nonetheless, many continue to hold onto this ideal of the transformative power of complementary therapies.

2.4 Historical context

So how did we arrive at the point where the potential of complementary therapies to transform the NHS is even being debated? I will now continue with a summary of the historical and contemporary influences that have led to the current situation in the UK.

2.4.1 History of biomedical dominance

Up until the mid-nineteenth century, biomedical physicians competed with bonesetters, homeopaths, herbalists and healers in an unregulated market (Turner, 2004). In this

country, biomedical physicians gained monopoly control with the adoption of the 1858 Medical Act, which came about through standardisation of training, professionalisation, organisation and leadership (Saks, 2003b). The General Medical Council then had the power to control who could practice medicine and who could not, although because of its popularity and links with the Royal Family, the Homeopathic Hospitals were tolerated (Dew, 2004). Interestingly, this increasing dominance was not brought about through biomedicine having greater scientific validity or evidence of effectiveness (Saks, 2003b), although collective emphasis on “rationality” and the importance of “scientific enquiry” was growing apace (Hills, 2005). Instead, Collyer suggests that the rise of biomedicine was due in no small part to its amenability to commodification and its compatibility with the values and hierarchy of the rising middle class (Collyer, 2004). It was not until the beginning of the 20th century that pharmaceutical developments led to biomedicine becoming more “scientific” (Porter, 2003). Indeed, the randomised controlled trial itself did not come into existence until the late 1940s, nearly a hundred years after the Medical Act.

This suggests that in the late 19th and early 20th century, the hegemony of biomedicine did not come about because of its innately superior perspective on health and disease conferred on it by the scientific method which many today believe (Glick, 2005). Rather it was due to organisational, societal and philosophical constructs that led it to enjoy sufficient clout to squeeze out its rivals. Biomedicine became dominant because it gained and wielded power - not because of greater inherent merit. Undoubtedly, in more recent times, great scientific advances have solidified that power, in what James le Fanu refers to as the “twelve definitive moments” from the discovery of penicillin in 1941 to the identification of *heliobacter pylori* as a major cause of ulcers in 1984 (le Fanu, 1999). But this was post hoc.

2.4.2 Challenges to biomedicine

Once gained however, that hold on power has been substantiated by widespread belief in the supremacy of rationality and science.

As the scientific community have grown strong, so they have developed specialised vocabulary, method, modes of analysis and practices of reason. Thus we confront the emergence of a new

“knowledge class”, groups who claim a superiority of voice over all others. Further without initiation into the class (typically through an advanced degree) one cannot challenge these claims. Opinions based on anything other than the standards of the knowledge class, for example on personal values, spiritual insights, commitments to another tradition – are largely discounted. In effect where the Enlightenment initially functioned to democratise society, it has now succeeded in generating a new form of totalitarianism (Gergen, 1999).

But the last 30 years have seen the rise of challenges to this “form of totalitarianism”, not least because of growing questioning that science can offer all the answers (Carter, 1998). Marginalised voices such as women and Black and minority ethnic communities are increasingly heard as they contest the “reality” of the “White Male System”, in which the scientific method upholds the values of rationality and logic above emotion and personal experience (Wilson Schaef, 1981). The growth of the cult of the individual, over and above the collective, challenges a basic premise of the scientific model which seeks to strip individuals of their context and place them within homogeneous groups for testing purposes. In doing so, the average of the group is prioritised over the experiences and outcome of the individual. Within health, the inability of science to adequately address the epidemic of chronic health disease has left proponents of the scientific method vulnerable to criticism. These phenomena are only part of a much wider cultural shift challenging science as the only determinant of knowledge and reality, a detailed discussion of which has been covered elsewhere (see le Fanu, 1999; Porter, 2003; Saks, 2003a; Hills, 2005). But despite these provocations, biomedicine has continued to hold sway over the past 150 years.

2.4.3 Medically pluralistic society

Nonetheless, alternative forms of healthcare have never entirely died out, although they did suffer great setbacks with the establishment of the NHS in 1948, when once again Homeopathic Hospitals were the only non-biomedical services permitted official state sanction (Saks, 2003b). Within the UK, a *laissez faire* attitude has been adopted by the state, where prosecution is rare as long as non-biomedical practitioners do not use titles such as “doctor” (Cant and Sharma, 1999). This co-existence of disparate forms of

healthcare has long prevailed; we have always lived in a medically pluralistic society (Cant and Sharma, 1999).

How has biomedicine responded to the challenge of a medically pluralistic society? Interestingly, this depends on the challenger. Take for example, the differing trajectories of counselling and complementary medicine.

Counselling and complementary medicine share many characteristics in that both:

- Fall outside the medical model in terms of their understanding of disease and approaches to promoting health
- Have largely been consumer driven
- Are highly individualistic
- Encompass wide ranging, difficult to define therapeutic modalities
- Frustrate clear identification of measurable, standardised health outcomes
- Are complex interventions that are less amenable to measurement by randomised controlled trials

In the early 1980s, both counselling and complementary medicine were 'fringe', but their course has been very different. In 1988 Jane McCleod, a GP, published her largely positive report on the issues surrounding incorporation of counselling for the Royal College of General Practitioners (McCleod, 1988). Counselling continued to make substantial inroads, helped no doubt by the financing of counsellors as ancillary staff by Family Practitioner Committees (then Family Health Service Authorities - FHSA) in 1990. This meant that GPs could receive reimbursement of up to 70% of the costs of counsellors (Corney and Jenkins, 1993). By 1993, it was estimated that one in three practices had access to a counsellor (King *et al.* 2000).

NHS counselling services continued to flourish during the 1990s. By the end of the 20th century, universities offered diplomas in counselling in health settings, the Counselling in Primary Care Trust was well established to facilitate the integration of counselling into medical settings, journals on counselling in the NHS had been set up and books telling the stories of counsellors working in a variety of NHS settings were published

(Etherington, 2001). In 2001, a flurry of evidence and guidance on counselling was published including an Effectiveness Matters bulletin (NHS Centre for Reviews and Dissemination, 2001a), a Cochrane Review (Bower and Rowland, 2001) and Department of Health Guidelines on using counselling in primary care (Department of Health, 2001c). Several trials, systematic reviews and evaluations of the impact of counselling on prescribing costs had also been carried out (Sibbald *et al.* 1996; Harvey *et al.* 1998; Hansell and Bonnet, 1999; King *et al.* 2000). Interestingly, these studies tended to find that there was a short term improvement amongst patients receiving counselling in comparison with control groups, but that counselling interventions did not reduce prescription rates or costs for psychotropic medications. 2005 saw the culmination of decades of hard work, as counsellors received recognised status within the NHS, with commensurate pay and grading scales.

Meanwhile, the picture for complementary therapies was very different. In 1986, the British Medical Association (BMA) published a report condemning alternative medicine as “witchcraft” (British Medical Association, 1986). In the early 1990s, complementary therapies enjoyed limited incentives in the state funded sector, the only one being health promotion clinics proposed by the “new” GP contract of 1991. This led to 14% of fund-holding practices, whereby GPs could pay for services themselves out of “practice savings”, taking advantage of FHSA funding (Cameron Blackie, 1993). Meanwhile, private provision of complementary therapies was expanding to the extent that the 1986 BMA position was no longer tenable. In 1993, they issued a second report on complementary medicine, which was considerably less antagonistic (British Medical Association, 1993). In this, the parameters of acceptance were set out in that complementary therapies capable of validating themselves on the “narrow orthodox touchstone of randomised controlled trials” (Saks, 2003a) might be considered for inclusion in state funded services, as long as a biomedical curricula component (usually anatomy and physiology) were included in practitioner training and biomedical physicians controlled the referral relationship (Saks, 2003a). Biomedical attitudes towards complementary therapies had softened considerably, but this was not due to the generation of scientifically valid evidence, but because “consumerist minded patients were less likely to be fobbed off with biomedical claims of absolute clinical authority” (Sharma, 2003).

In 1995, four years after the advent of fund-holding, the availability of complementary therapies had increased to around 40% of all practices (Thomas *et al.* 2001b). However, this figure could be somewhat misleading because volume was not measured, so it included those practices that referred even just one patient to a complementary therapy intervention. Nonetheless, the signs suggested that complementary therapy service provision in or via the NHS was growing. For example, a survey of a local health authority published in 1998 found that half of 175 practices offered access to complementary therapy interventions, most commonly delivered by a doctor (82%) (Wearn and Greenfield, 1998). In 2001, a follow up study to the 1995 survey carried out by Thomas and colleagues found that nearly 50% of general practices now had access to complementary therapies (Thomas *et al.* 2003b).

Unfortunately for complementary therapies, fund-holding was abolished towards the end of the 20th century and with it access to complementary therapy services in the NHS was hampered. Services were also less likely to be free at the point of delivery, as patients paid for the treatments themselves (42% in 2001 versus 26% in 1995) (Thomas *et al.* 2003b). More positive for integration proponents was the finding that the proportion of professional therapists working within GP surgeries had doubled from 6% in 1995 to 12% in 2001 (Thomas *et al.* 2003b). Although growth was slowing and the NHS was shifting the financial burden of complementary therapies to patients, complementary therapies still had a slippery toehold in the NHS.

But compared to counselling, this was not great. In 2003, in the previously mentioned mapping exercise carried out with the University of Westminster, I found that only seven GP practices in total across seven counties in the entire South West region offered complementary therapy services funded by PCTs (Wilkinson *et al.* 2004a). This contrasts with reports that suggest that between 60-70% of GP surgeries nationally offered access to counselling in 2005. (www.bacp.co.uk accessed 28.9.05). Moreover, from early 2006, the position of complementary therapies in the NHS has become even more fragile. In attempts to address the dramatically growing NHS deficit, many long standing complementary therapy services have been cut and even the Homeopathic Hospitals are under threat (Clews, 2007). Meanwhile, following NICE recommendations, in November 2006 the Department of Health recommended the

use of computerised cognitive behaviour therapy (CBT) programmes for the management of mild and moderate depression as well as panic and phobia. PCTs were expected to offer these interventions less than six months later (by 31st March 2007) (Mayor, 2006). This graphically illustrates the disparity between the tenuous position of complementary therapies within the NHS and the widespread uptake of at least one of the “talking therapies”.

2.5 Current context

Having given an overview of key characteristics of complementary therapy usage, access and the historical background, I will now continue with a discussion of some (but by no means all) of the contemporary drivers of the mainstreaming agenda from a variety of perspectives including users, the state (policy makers and commissioners), practitioners and professional bodies.

2.5.1 The public’s attitude to complementary therapies

At the forefront of the move towards incorporation of complementary therapies into the NHS are patients, who are widely perceived to want greater access to complementary therapies. But the most recent large scale survey to support this belief, finding over three-quarters of the sample in favour, is over 15 years old (MORI, 1989). Nonetheless, despite a comprehensive survey being long overdue, many subsequent smaller studies do still support this supposition (Ong and Banks, 2003; Richardson, 2004; Shaw *et al.* 2006b).

Perhaps public enthusiasm for complementary therapies is due in part to patients progressively experiencing more chronic complaints and symptoms related to lifestyle choices, the very conditions biomedicine finds difficult to treat. In 1999, the Department of Health estimated that over one in three people in the UK were living with a long term condition (Department of Health, 1999), which was confirmed in the 2005 manifesto of the 17 million reasons alliance (see www.17millionreasons.co.uk). Furthermore, chronic conditions are the most common cause of death in the Western world (Davis *et al.* 2000). In addition, studies generally find people with chronic conditions have poorer health status and are more likely to use complementary therapies (Eisenberg *et al.* 1998; Thomas *et al.* 2001a; Nielsen *et al.* 2005; Busato *et al.*

2006). So the demand for complementary therapies is perceived as growing (at least in theory) at a time of greater prevalence of exactly the illness conditions for which complementary therapies are most suited.

2.5.2 The state

2.5.2.1 Policy makers

In consequence, the state finds it increasingly difficult to ignore complementary therapies. In 1999, a political response was the establishment of a working party within the House of Lords, at a time when NHS complementary therapy services were probably at their most prolific, after several years of fund-holding. Charged with exploring the implications of complementary therapy provision on public health, the Committee's conclusions were that:

- The evidence base for many therapies is weak and robust research into their efficacy is needed.
- The regulatory framework should be stronger to ensure that practitioners are properly trained and supervised.
- Only well regulated therapies should be provided by the NHS and then only through a referral from a GP.
- There is a need for information and more effective guidance for the public.
- Legislative avenues should be explored to better control the unregulated herbal sector (House of Lords, 2000).

In their response to this report, the terms of state funded inclusion were clearly laid down by the government:

CAM [complementary and alternative medicine] can also play a part in treating NHS patients. But if it aspires to be an equal player with other forms of NHS treatments, it must meet the same standards requested of them (Department of Health, 2001a).

Many of these standards, such as regulated professional training and increased provision of information, are being addressed, but the biggest hurdle is the production of “evidence” of effectiveness, safety and efficacy that satisfies the stringent

requirements of most of those trained in the scientific tradition. This will be dealt with in more detail in later chapters. But suffice it to say here, that evidence based medicine (and by extension evidence based policy making) comes into constant friction with the highly espoused value of patient choice.

The policy discourse on patient choice has been growing over the past few years. In fact, every year since 2003 has witnessed the publication of Department of Health documents re-affirming their commitment to patient choice (Department of Health, 2003; Department of Health, 2004; Department of Health, 2005; Department of Health, 2006b; Department of Health, 2006a). For example, in *Creating a patient led NHS*, Sir Nigel Crisp, latterly the NHS Chief Executive, clearly puts patients at the heart of reform by stating

...the ambition for the next few years is to deliver a change which is even more profound - to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health - a fundamental change in our relationships with patients and the public. In other words, to move from a service that does things to and for its patients to one which is patient led, where the service works with patients to support them with their health needs (Department of Health, 2005).

A number of mechanisms have been put forward to help facilitate this revolution such as:

- A new GP contract which allows practices to employ a range of healthcare professionals.
- Alternative provider medical services which permit the employment of providers of care and services from the private or voluntary sectors rather than solely from the NHS.
- “Choose and book” whereby the patient is given four or more treatment options for hospital care.
- Practice based commissioning and enhanced services through which, it is reasoned, devolved commissioning powers to GPs will align services more closely to patient preferences (Thomson, 2005).

Despite their intentions, some of these initiatives have not been adopted with quite the enthusiasm that the government had hoped. For example, a recent qualitative study found that the implementation of “choose and book” was haphazard (Rosen *et al.* 2007). Moreover in July 2006, six months before the target of 100% uptake was to be met, only 40% of the GP practices in England were “signed up” to practice based commissioning (O'Dowd, 2006). By February 2007, the Department of Health announced almost 100% coverage (see www.dh.gov.uk with links to practice based commissioning monitoring), but a recent report suggests that implementation is patchy (Lewis *et al.* 2007). Nonetheless, despite slow uptake, in theory at least, the current government is committed to patient choice.

To wit, the only recent policy document to explicitly explore the relationship between complementary therapies and patient choice is *Building on the Best* (Department of Health, 2003). Its authors suggested that commissioners “develop a framework for access to complementary medicine” (p. 23). But as no further details or concrete targets were given, undoubtedly this brief mention was overlooked by most.

This highlights a highly political aspect of the choice agenda. Choice is usually “managed”, whereby consumers can select between two or several predetermined options (Evans, 2005). But who decides what those options should be? Consumers? Policy makers? Or in the case of complementary therapies, clinicians? Furthermore, is patient choice being used as a decoy to put pressure on providers? (Appleby *et al.* 2003) Many, including academics (Pollock, 2005; Dixon, 2005), doctors (Kmietowicz, 2006), unions (Eaton, 2007) and even children's writers (Arie, 2005), see the creeping privatisation of the NHS behind this recent avalanche of market economy style mechanisms. If this is so, then where do private providers like complementary therapists, who may not make the “managed choice” shortlist of the state but definitely feature on that of the public, fit? Will increasing privatisation enhance the mainstreaming opportunities for complementary therapies, or threaten them?

Irrespective of the implications of the patient choice agenda on the provision of complementary therapies, overall the aim is to ensure that patients metamorphose from their current depiction as passive health recipients to more active, assertive, responsible self-health creators. However, a major obstacle to this appears to be patients

themselves. A recent MORI poll found that only about 20% surveyed said they knew a “great deal” or “fair amount” about patient choice (MORI, 2006); the rest are unaware. Presumably, an essential first step to creating more responsible, motivated and ultimately healthier patients is illuminating them with knowledge of their newly granted powers.

Regardless, many of the rhetorically cited values behind these new wave NHS initiatives are present within complementary therapy philosophies and approaches, for example relationships between provider and client are seen as more egalitarian, complementary therapy users are active co-creators of their health and therapists take the role of facilitators rather than experts (Kelner, 2003b). So, a strong driver towards the mainstreaming of complementary therapies is that many of its inherent values are now high on the policy agenda and facilitative mechanisms are in place, even if policy makers themselves seem largely blind to the potential of complementary therapies to bring about their agenda.

2.5.2.2 Commissioners' attitudes to complementary therapies

Caught in the middle, charged with implementing inconsistent, paradoxical government policies, while responding to local demands for service delivery, are the commissioners. How do they view state funded complementary medicine?

Well, they (rather understandably) prevaricate. A conference organised by the NHS Alliance in 2002 highlighted many of the problems NHS commissioners face (NHS Alliance, 2002). At this event, several PCT Chief Executives, non-executives and Chairs were invited to hear evidence about complementary therapy options and decide their suitability for funding. For St. John's Wort, where the evidence was found convincing, the panel felt they had to defer the decision to a national level because of issues of accountability. For treatments such as homeopathy, the panel argued that the agreement of the executive committee, sub-committees and the PCT Board as a whole would need to be secured and the funding of a homeopathy service would be stacked up against national “must do's”. In using complementary therapies in palliative care, the panel was concerned that demand would outstrip supply. As for acupuncture for osteoarthritis, the panel simply thought that the evidence was unconvincing and the

local need was negligible. So even in cases where the evidence was accepted, with the panel veering towards a favourable review (and this was by no means always the case), the commissioners identified many complex political and organisational impediments to the funding of complementary therapy services by the NHS.

More rigorous academic studies confirming these views are scarce; I could only find three. An English study with Chairs and Directors of Primary Care Organisations carried out from 1999 to 2001 found “brakes” to the local development of complementary therapy services included: the need for equitable access to services, lack of scientific evidence, absence of quality assurance mechanisms, cost pressures, competing priorities/NHS agenda and prevailing beliefs and attitudes. “Drivers” included: existing complementary therapy service provision, GP interest and champions, local evidence of benefit and satisfaction, patient demand, intersection with NHS policies, Health Authority funding and growth money (Thomas *et al.* 2004). In another study, Canadian state healthcare commissioners, rather than NHS funders, were interviewed (Kelner *et al.* 2004). Commissioners identified a tension between protecting the public and responding to consumer pressure for complementary therapies, while safety, efficacy and cost containment were the chief reasons for not funding complementary therapy services. An English survey of 28 health authorities in London found the same three predominant concerns (van Haselen, 1998). So overall, commissioners are hesitant to commit funds to complementary therapy services.

However, a potential lever that may interest them is the potential for complementary therapy services to reduce costs, especially those associated with secondary care. Currently, the impact of complementary therapy services on NHS costs is not clear. A feasibility study exploring the use of homeopathy and acupuncture services for dyspepsia patients found that there was no difference in prescription or consultation costs between those in the complementary therapy service group and those treated with usual care (Paterson *et al.* 2003). In a review of five studies on acupuncture and spinal manipulation, the authors concluded that complementary therapy interventions incurred additional health care costs (Canter *et al.* 2005). But a ‘rapid response’ challenging that conclusion pointed out that cost benefit rather than overall costs were important and three of the five studies found a cost benefit (Paterson, 2005). A study

of prescription rates at the Royal London Homeopathic Hospital found that 28% of audit patients stopped conventional medication use after 6 months and 32% reduced their use, but 15% who had not previously used medication were now using it, suggesting an increase in prescription rates for some (van Haselen, 2000). More positively, a review of 56 economic evaluations of complementary therapies found that complementary therapies were cost effective over usual care for several conditions including:

- Acupuncture for migraine
- Manual therapy for neck pain
- Spa therapy for Parkinson's
- Self-administered stress management for cancer patients undergoing chemotherapy
- Oral nutritional supplementation for lower gastrointestinal tract surgery
- Biofeedback for patients with functional disorders such as irritable bowel syndrome
- Guided imagery, relaxation therapy and potassium rich diets for cardiac patients (Herman *et al.* 2005)

So the impact of complementary therapy services on a key priority of NHS commissioners - that of containing or reducing costs - is unknown.

2.5.3 NHS professionals' attitudes to complementary therapies

Although few studies have explored commissioners' views on complementary therapies, a growing number have been conducted with doctors (Wharton and Lewith, 1986; White *et al.* 1997; Norheim and Fonnebo, 1998; sikand and Laken, 1998; McLellan *et al.* 2005; Cohen *et al.* 2005; Frye *et al.* 2006). Reviews of studies are also becoming increasingly common (Ernst *et al.* 1995; Astin *et al.* 1998; Botting and Cook, 2000). These tended to find that doctors were sympathetic towards certain types of complementary therapies, predominantly the manipulation therapies and acupuncture, but other popular therapies such as reflexology and aromatherapy, were dismissed (Ernst *et al.*, 1995; Astin *et al.*, 1998; Botting & Cook, 2000). Doctors were concerned about lack of scientific evidence, their own inadequate knowledge, large fees,

insufficient regulation and the possibility of harmful effects (Botting and Cook, 2000). But although doctors might evince some support for complementary therapies, albeit with reservations, this by no means indicates that they believe complementary therapies should be state funded.

Many of the studies with physicians have attempted to explore the relationship between doctors' attitudes to complementary therapies and their subsequent reported referral behaviour. Despite this burgeoning literature base, findings are inconclusive (Hirschhorn and Bourgeault, 2005). This is largely, I believe, because the majority of studies have been cross sectional surveys, which do not give the scope to explore complex behaviours such as referral patterns and overlook the discrepancies between reported and observed behaviour.

For instance, in some surveys, doctors report that an observed beneficial effect on patients or personal or family use encouraged more positive attitudes and corresponding referrals to complementary therapies (Wharton and Lewith, 1986; Norheim and Fonnebo, 1998; McLellan *et al.* 2005). A recent study with over 600 physicians from the Mayo clinic found that prospective randomised controlled trials and scientific evidence of the mechanism of action were more likely to persuade than personal experiences of family, friends or colleagues (Wahner-Roedler *et al.* 2006). An unusual study in Australia exploring referral patterns to chiropractors from private and state funded physicians found that private doctors were more likely to refer (Greene *et al.* 2006). In summary, the latest comprehensive review reports a multitude of potential influences on doctors' attitudes and referral behaviour (see Table 1 below).

Table 1 Influences on physicians' attitudes and referrals to complementary therapies

<ul style="list-style-type: none"> • Age • Availability of CAM providers • Colleagues' attitudes • Disease characteristics/prognosis • Education • Ethnicity • Evidence • Experience (in years) • Familiarity with CAM 	<ul style="list-style-type: none"> • Family behaviour • Finances of patient • Finances & finance mechanisms of practice • Health locus of control • Gender of provider • Hospital setting • Liability/legal issues • Management • Media • Modality of CAM 	<ul style="list-style-type: none"> • Number of colleagues in practice • Patient preference • Personal views • Public/private sector • Space/facilities • Specialization • (The) State • Status of provider • Strategic reasons • Time/availability
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(Hirsch Korn and Bourgeault, 2005)

So, many factors may potentially contribute to doctors' views on complementary therapies and their referral behaviours. But doctors are not the only NHS professionals whose attitudes towards complementary therapies have been studied.

A survey of 1000 nurses found that they were most likely to recommend multivitamins, massage, meditation, relaxation or counselling (Brolinson *et al.* 2001), which starkly contrasts with the most popular complementary therapy interventions identified by doctors. Over 70% of nurses in one study (n=153) believed that complementary therapies should be integrated into clinical care (Tracy *et al.* 2005; Kim *et al.* 2006) and further education on complementary therapy use would facilitate this (Tracy *et al.* 2005; Laurenson *et al.* 2006). So there appears to be some discrepancy between the cautious acceptance of doctors of therapies such as osteopathy, chiropractic and acupuncture and the more enthusiastic response of nurses who would like to incorporate self-help approaches such as nutritional aids, meditation and relaxation.

One survey explored the views of both doctors and nurses in primary care. Over 200 questionnaires were returned, three quarters of which came from doctors. Only 6% were against any form of complementary therapy provision within the NHS, but of those who were in favour, 82% believed that these interventions should be provided by biomedical practitioners - ideally doctors (van Haselen *et al.* 2004).

2.5.4 Complementary therapy professional organisations

Complementary therapy professional organisations, on the other hand, appear united in their belief that complementary therapies, and in particular their specific therapy, have a place in the NHS. Professional organisations such as the General Osteopathic Council (www.osteopathy.org.uk), the General Chiropractic Council (www.gcc-uk.org), the Society of Homeopaths (www.homeopathy-soh.org), the Faculty of Homeopathy (www.trusthomeopathy.org), the British Acupuncture Council (www.acupuncture.org), the British Medical Acupuncture Society (www.medical-acupuncture.co.uk), the British Complementary Medicine Association (www.bcma.co.uk) and others have worked hard to promote the mainstreaming agenda, principally through persuading their members to self-regulate and stimulating the research agenda. But in spite of state funding being a goal of many professional complementary therapy organisations, individual practitioners may hold contrary views, with concerns about “poaching” of complementary therapy interventions by biomedical professionals, loss of professional autonomy and fears that they will sacrifice their distinct identity as “alternative” practitioners for state sanctioned legitimacy (Cant and Sharma, 1999; Welsh *et al.* 2004; Boon *et al.* 2004b).

2.5.5 Other influential individuals and organisations

Despite (or perhaps because of) this ambivalent, highly charged context, the issue of mainstreaming complementary therapies has continually boomeranged back onto the political agenda over the past 15 years, principally due to the efforts of a couple of influential figures and organisations.

One is Dr. Michael Dixon, chair of the NHS Alliance, which is the main representative body for commissioners, allied health professionals and dentists, as well as other NHS professional disciplines. This organisation has sponsored several conferences on mainstreaming and their website has an entire section dedicated to complementary medicine. (see www.nhsalliance.org) Dr. Dixon has written extensively about the advantages of mainstreaming (Dixon, 2003), largely influenced by his experience as a GP working in a practice which employs spiritual healers.

Another key figure is His Royal Highness the Prince of Wales. In 1996, the Prince set up the Foundation for Integrated Medicine, more recently known as the Prince of Wales's Foundation for Integrated Health, to work towards the incorporation of complementary therapies into the NHS (see www.fihealth.org.uk). To do this, the Foundation organises conferences, publishes guidelines and reports and gives awards to outstanding NHS complementary therapy services. For example, an initiative that had a major influence was the recommendations of four Working Groups to explore the areas of: research and development, education and training, regulation and delivery mechanisms (Foundation for Integrated Health, 1997). In their report, many of the ideas later proposed by the House of Lords and acted on by the government were first mooted. In 2000, the Foundation worked with the Department of Health, the NHS Alliance and the National Association of Primary Care to produce an information pack for NHS commissioners (Bonnet, 2000). More recently, with the change of Chief Executive, the focus of the Foundation has moved from solely concentrating on the incorporation of complementary and alternative therapies into the NHS to a broader remit encompassing wellbeing and self-care.

Despite biting criticism from some members of the medical community (Baum, 2005) and defamatory television exposés, such as the March 2007 *Despatches* television programme (in which the Prince was accused of inappropriately using his influence to promote the “integration” agenda - see www.princeofwales.gov.uk), the Prince continues to support complementary therapies in other ways. For instance, the Prince commissioned the controversial Smallwood Enquiry.

The Smallwood Enquiry was charged to explore the cost effectiveness of complementary therapies within the NHS. Using four case studies, researchers focused on several outcomes, including health status, secondary care referrals and GP consultation and prescription rates (Smallwood, 2005). One site was unable to offer these data (Westminster PCT) while another (GetWellUK) demonstrated positive health benefits and a decrease in secondary care referrals but an increase in GP consultation and prescription rates (Robinson, 2005; Robinson *et al.* 2006). A third site (Newcastle PCT) produced a report of poor methodological quality (Solomon, 2003). Only the fourth site, Glastonbury Health Centre, demonstrated improvements in

health status in addition to reductions in prescription, GP consultation and secondary care referral rates (Hills and Welford, 1998; Smallwood, 2005). Despite the inconclusiveness of the data from the four case sites, the Enquiry concluded the mainstreaming of complementary therapies might lead to NHS cost savings.

Reaction to the report was mainly muted - with exceptions. Unsurprisingly, some complementary therapy professional associations, such as the General Chiropractic Council (www.gcc-uk.org) and the Society of Homeopaths (www.homeopathy-soh.org), welcomed the report, although many made no comment. Professor Edzard Ernst, who initially was a study participant but then very publicly withdrew (Henderson, 2005), announced that the methodology was fundamentally flawed (Ernst, 2006). The leader in the British Medical Journal (BMJ) was more moderate (Thompson and Feder, 2005), but the first rapid response on the BMJ website from Richard Horton, Editor of the *Lancet*, was explosive.

Have doctors really become so deluded by the Prince, his wayward meanderings into the recesses of medievalism, and a credulous public that we are prepared to sacrifice all of the advances of scientific medicine on the grounds of compromise with quackery? It seems to be so for some of our medical leaders. One can only sigh in despair or turn away in disgust. The Prince's report is itself potentially life-threatening. Doctors should come out and say so instead of pandering to a Prince for reasons that are both inexplicable and mysterious (Horton, 2005a).

Clearly, Horton is amongst that group of doctors who are not in favour of complementary therapies – in any form. More noteworthy, however, was that his colleagues did not “come out” as Horton urged. Instead, the majority of early subsequent responses suggested that many found Horton’s views more unacceptable than those of Smallwood (see www.bmj.com rapid responses to Smallwood report 2005; 331(7520)).

Nonetheless, some doctors are in sympathy with Horton. In the past two years, members of the Association of Public Health and a few doctors, mainly from pharmacological backgrounds, have founded a group called “Sense about science” (see www.senseaboutscience.org.uk), which strikes out annually at NHS complementary therapy provision, particularly homeopathy. On May 23, 2006, the same day as the Prince of Wales was due to give an address on complementary therapies to the World

Health Organisation, they published an open letter in a major national newspaper calling for the closure of NHS homeopathy services citing lack of evidence (Baum *et al.* 2006). Exactly one year later, the attacks were repeated in the national press (Born, 2007). In addition, selected Chief Executives and Directors of Public Health were sent an electronic copy of a PCT Board paper that could be used as a template to decommission services from the Homeopathic Hospitals (Crayford, 2007). Evidently, lobbyists from both sides feel passionately about the issue of the mainstreaming of complementary therapies.

2.6 Summary of key points

This chapter began with definitions of key terms and then gave an overview of complementary therapies, including prevalence of use, user characteristics, points of access and models of “integration”. It then continued to summarise historical developments and went on to discuss drivers that push the mainstreaming of complementary therapies on to the political agenda. Key points are:

- About 10% of the English and Welsh population visit a complementary therapist annually; potentially that figure has remained stable since the late 1990’s. However, tremendous growth in the commercialisation of complementary therapies, particularly over the counter products, and increased exposure through the media may contribute to the perception that complementary therapy usage is increasing.
- Many service models of ways to access complementary therapy treatments and techniques in the NHS exist including:
 - fully mainstreamed services with rolling contracts funded by PCTs
 - biomedical practitioners offering complementary therapy techniques during usual consultations
 - PCT funding of professional therapists
 - state funding (non-NHS) of professional therapists
 - mixed models that obtain funding from any combination of PCT and practice budgets as well as charitable trusts and patient donations
 - therapists who rent rooms in NHS premises but receive private funding
 - therapists who offer free treatments on NHS premises

- Biomedicine began gaining ground in Western countries over other healthcare alternatives, roughly a half century before the advent of “scientific” medicine, mainly due to political, societal and organisational movements. Scientific advances have since solidified that early gain, although they may now be tailing off.
- Although no group is homogenous in its views, generally speaking proponents of mainstreaming include: the public, professional complementary therapy bodies and key individuals and organisations such as the Prince of Wales’s Foundation for Integrated Health, the NHS Alliance and the Prince of Wales himself. Groups that are more ambivalent include: NHS policy makers, commissioners and clinicians. Some lobbyists, such as Sense about Science, are clearly hostile.
- The government has issued a series of directives promoting both evidence based decision-making and patient choice, which often, in the case of complementary therapies, conflict. This leaves NHS commissioners, charged with the execution of these policies, in a stalemate.
- Ostensibly, a potential lever to break that deadlock could be the demonstration by NHS complementary therapy services of an impact on NHS costs by reducing rates of prescriptions, GP consultations and secondary care referrals. The recently published Smallwood Report took that tack, concluding that such reductions were possible, although the data to support this were limited.

2.7 Conclusion

This chapter has covered definitions of terms, provided an overview of complementary therapy usage and state-funded points of access, discussed the historical and current context of complementary therapy provision and outlined the thesis structure. The following chapter presents the methods used to address the study questions.

CHAPTER 3 Methods

3.1 Introduction

The aim of this chapter is to discuss the methodological approaches used in this study of the mainstreaming of complementary therapies into the NHS. This chapter begins with a discussion of epistemological and ontological positioning to provide context for the approach adopted. It continues with details on the methodology and sources of data and concludes with some reflections on the research process.

3.2 Qualitative methods: knowledge and reality

Qualitative methods are useful for exploring unknown territory and little research has been conducted into the complexities of mainstreaming complementary therapies. Qualitative approaches have long been used in the social sciences and are gaining prominence in health services research (Pope and Mays, 2000b). They are ideal for looking at interactions between individuals within healthcare settings (Fulop *et al.* 2001) and offer the potential to “document the world from the point of view of the people studied in their natural rather than experimental settings” (Hammersley and Atkinson, 1995). In qualitative research, the ways in which “people interpret and construct their world and give meaning to events and interactions are studied through their words and their behaviour” (Patton, 2002).

In placing qualitative studies into context, researchers need to clearly state their perspectives on epistemology (knowledge) and ontology (reality) (Mason, 1996). To that end, I believe that knowledge is gathered through observing interactions and discussing interpretations and meanings. Moreover, “the personal value is that in hearing the narratives of others we examine and re-interpret our own” (Mason, 1996). Furthermore, knowledge can also be gained experientially through using ourselves within the research process, by reflecting on emotions, thoughts and physical body reactions (Etherington, 2004). Other vehicles for knowledge acquisition in this study included:

- Listening to, reading about and observing the experiences of others
- My own personal lived experience

- Documentary records
- Impressions gained from sensory organs, emotional responses and thoughts

My views on ontology are less consistent, not least because in carrying out this work, I have moved between two roles – those of researcher and therapist. As a researcher, I behave as if reality is knowable and a composite picture of that reality can be constructed through the careful piecing together of information from a kaleidoscope of sources. Although in parallel, and somewhat in tension with this perspective, in my rhetoric, I maintain there are multiple, valid world views and no one “right” version of reality. As a health service researcher, my role is to gather, analyse and elucidate multiple perspectives so that a whole comes out of the parts with the goal of (ideally) informing policy and practice. So in this guise, I treat knowledge and reality as contextual but able to be articulated. Furthermore, as a researcher, time is linear with a distinct past, present and a future that runs serially.

But as a therapist, my perspective on knowledge and reality is very different. Through working with energy, I have come to question my researcher perspective, especially ‘time’ as we currently understand it. I have had countless experiences where I have ‘known’ something about my clients’ past, without them telling me, by sensing it energetically. In my practice, I also go forward into the future to access information for treatment sessions that have yet to take place. In addition, I can identify current disturbances and imbalances that clients may not consciously know exist, but later find confirmed. As an energy therapist, the process of obtaining knowledge is not packaged and transferred through verbal or written means, but it is sensed, intuited and sometimes cannot be translated or expressed, because it is an impression. Rather bewilderingly, time runs concurrently, overlapping the past, present and future.

In managing the tension between these two roles, I do not adopt a middle ground. Rather, it requires switching between two completely different mindsets, based on the context in which I find myself. Because of those contradictions, I embody the belief that not only are research participants subject to multiple and divided selves, so are researchers (Blumenthal, 1999; Sandelowski, 2002). Throughout the course of this thesis, I have grappled with resolving this and have come to two conclusions. One is that my dilemma is reflected in the bigger question of how energetic and biomedical

worldviews could co-exist organisationally in the wider context of healing, without one co-opting or neutralising the other. The second is the importance of acknowledging both the strengths and weaknesses of having two simultaneously running belief systems. It might be that my intelligence (and integrity) is being sorely tried, as F. Scott Fitzgerald remarked:

The test of intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function (Fitzgerald, 1945).

Because of that inherent duality, perhaps unsurprisingly, I was drawn to case study methodology with its attributes of pursuing an enquiry through multiple methods, sources and perspectives.

3.3 Case study methodology

To recap, the research question is: how does the complementary therapy community have to adapt to be mainstreamed within primary care? This thesis does not address the “should” question, specifically “should complementary therapies be mainstreamed?”, as that was beyond the scope of this study. Instead, it addresses the “could” question: “In its current incarnation, could complementary therapy provision become mainstreamed in the NHS?”

To answer the research question, I considered and discarded several methodological traditions, but eventually a case study approach was chosen. As an applied health services researcher, a case study approach appeared most appropriate. According to Yin, case studies are indicated when:

Investigating a contemporary phenomenon within its real-life context when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used (Yin, 2002).

Case studies are usually qualitative, although there is scope for use of some quantitative techniques. Data are collected from multiple sources, in this case documents, observations and interviews. Furthermore, case studies are indicated within complex, dynamic contexts in which it is “difficult to isolate variables or there are strong interactions between variables” (Yin, 2002).

A criticism of qualitative case study methodologies is the lack of generalisability or transferability (Firestone, 1993). Quantitative research is based on generalising from a sample to the parent population with a set of rigorous, largely accepted techniques. A difficulty arises when the same criteria are applied to qualitative research, with the expectation that qualitative results should be extrapolated to a broader population. This is usually inappropriate and can lead to conclusions being drawn from qualitative studies that over-reach their findings. Quantitative social surveys tell a small amount about many cases; qualitative case studies provide a wealth of information about a few (Ragin and Becker, 1992). The strength of qualitative research is the understanding that in-depth work studies provide. Moreover, qualitative studies can generate hypotheses to be tested on wider samples using other methods (Yin, 2002). In addition, the utility of case studies, whether single or multiple, is in transferring findings from a case to a theory and then applying the theory to other cases (theoretical replication) (Yin, 2002). In generating “thick description” (Fetterman, 1989) by portraying settings, events, interactions and people, vividly and in detail, case study researchers can enable their readers to transfer the learning from these cases to “cases” known to them. This implies work and willingness from readers, but the transferability from this type of study is no less valid. Rather than being researcher led, it is reader generated.

3.4 Sampling frame for case sites

Qualitative inquiry typically relies on purposeful sampling techniques, as “information rich” cases are chosen to yield insights and in-depth understandings (Ritchie and Lewis, 2003). Thus, selection of settings and participants as cases necessitates care. The mapping study I was involved in during 2003 (Wilkinson *et al.* 2004a) led to the construction of a typology of complementary therapy services (see 2.3.4). Several additional criteria were then applied to identify specific sites for inclusion in the study. Initially, the first criterion was that the services were delivered by professional therapists in primary care settings rather than by biomedically trained practitioners. This was modified, however, on meeting doctors who operated almost entirely within a complementary therapies framework and labelled themselves as “healers”. Therefore this criterion became – practitioners who worked primarily within complementary therapy paradigms of healing.

The second criterion for case selection was the funding source of the complementary therapy service. Complementary therapists who rented rooms within GP surgeries and charged patients full rates were excluded, as they offered private provision on state premises rather than state provision on state premises. My reasoning behind this decision was that a linear continuum existed from this type of service to those obtaining full PCT funding. In selecting cases, not only did I want to choose sites where different mechanisms of funding operated (e.g. NHS versus non-NHS) but I also wanted to recruit a site where services appeared to be valued by NHS professionals, as I assumed that a service that was more highly esteemed might be more mainstreamed.

The third criterion for case selection was that the service offered therapies that were routinely denied mainstream funding. For this reason, services offering counselling or psychotherapy alone were not included, as around 60% of general practices offer such provision (Hodson and White, 2005).

Less tangible criteria also played a part in the construction of the sampling frame. Stake argues that case sites should be selected where the people, groups or organisations offer the greatest potential to learn (Stake, 2000). Hence, those sites offering extensive access to a wide range of situations, activities and people are good candidates. Good prior relationships between the researcher and participants are essential, because people generally do not like being observed and a multitude of gatekeepers are indicated. Gatekeepers included: GPs to the surgeries, co-ordinators to the therapists, therapists to the patients and commissioning managers to the PCT. The importance of prior relationships was borne out, as I invited two potential sites where I was not known to take part. Both declined.

3.4.1 Case sites selected

Full descriptions of the case sites are given in chapter 5. But briefly, the first case site was selected as it met each of the above criteria and all gatekeepers agreed to take part in the study. This complementary therapy service was located in an inner city area in southern England and served two GP surgeries. It was funded by regeneration money granted by the Office of the Deputy Prime Minister for nearly five years. As a community project, its ethos emphasised outreach to marginalised, disadvantaged

groups such as refugees, the elderly and drug and alcohol users, of which there were many in the local population. The service originally offered around ten therapies, provided by professional therapists for any condition accessed through referral from a NHS professional or through self-referral. However, after fieldwork had finished, it received PCT funding for a radically redesigned service, offering three therapies for musculoskeletal conditions contingent on NHS referral. Fieldwork began in July 2004 and continued until June 2006, although the majority was completed by September 2005. A key finding was although the service was heralded as an exemplar of “integration”, in practice it led a parallel, marginalised existence. This finding influenced the selection of the next case site.

The next site was chosen to contrast with the first, as it appeared more closely mainstreamed with features such as continual NHS (PCT or Health Authority) funding, rolling contracts and excellent inter-professional relationships between therapists and NHS clinicians. In adhering to Yin’s principle of theoretical replication (Yin, 2002), as fieldwork finished at the first site, a series of hypotheses were drawn up to assess against the second. Since the primary purpose of the second site was to test these out, data collection was not as extensive.

Based in an inner city area in northern England and serving a citywide population, the complementary therapy service at the second site had been operational for eight years when fieldwork began. Three therapies were offered for women with hormonal conditions and delivered by three practitioners - a doctor, a nurse and a professional therapist – all of whom worked within the complementary therapy paradigm. The complementary therapy service was part of a wider women’s health service based in a community clinic. Self-referrals and referrals from any NHS professional were permitted to the women’s health service, but only one of three specialist doctors based in the women’s health clinic could then refer onto the complementary therapy service. Shortly after fieldwork began, the aromatherapy and reflexology service was stopped as the therapist retired. A few months later, unexpectedly, the homeopathy service was also cut. Fieldwork was conducted from January to June 2006.

Ethics approval was received from the London Multi-centre Ethics Committee in the summer of 2004. Research governance approval was obtained from local PCTs.

3.5 Data sources

Although this study is primarily qualitative, I have also used some quantitative techniques. Greene's framework of reasons for using mixed methods identifies several attributes that apply to this study including:

- Complementarity – to elaborate, enhance or clarify the results from one method with the results from another
- Development – to use the results from one method to help develop or inform the other method
- Initiation – to explore paradox and contradiction
- Expansion – to extend the breadth and range of inquiry by using different methods for different inquiry components (Greene *et al.* 1989).

By exploring data from multiple sources, I aim to “increase the researcher's confidence so that findings may be better imparted to the audience and to lessen recourse to the assertion of privileged insight” (Fielding and Fielding, 1986). Patton notes that using multiple sources allows for the comparison of:

- *What is observed with what is said*
- *What is said in the public and private sphere*
- *Consistency for what is said over time*
- *Perspectives of people from different views*
- *What is said and what is written (Patton, 2002)*

He also warns that this approach does not lead to a single, consistent picture, but rather different types of data portray different aspects (Patton, 2002). I find of chief fascination is the potential discord between what we say we believe and how we behave. This goes beyond the ideas of public and private self, as our discrepancies often remain unknown and unsuspected by ourselves. To capture and explore those potential dichotomies, more than one data source was required.

In summary, I have collected data principally from interviews, observations of complementary therapy consultations and documentation to elaborate, inform and extend the results from one source to another and explore contradictions. Details on the way in which the three data sources were compared and combined are discussed in section 3.5.5. I will continue by presenting each source in turn.

3.5.1 Interviews

Interviews with participants from case sites and those in the broader field of complementary therapies were chosen as a source of data, as through gathering people's knowledge, views and interpretations, their social realities can be explored. This can be achieved through talking and listening to those engaged in the topic under study (Mason, 1996).

3.5.1.1 Key informant interviews

The first stage of the study involved undertaking interviews with key informants. Key informants introduce the researcher to the topic through formal and informal interviews (Gilchrist, 1992) and may better define the area under study (Tremblay, 1991). In the summer of 2004, I interviewed four therapists with this purpose. Two were chosen because they were willing to repeat their experience of working in a complementary therapy service in NHS premises. I also interviewed a "failure" (Becker, 1998); a therapist who had worked in the NHS and would refuse to do so again. In all three instances, the informants were from services excluded from the sampling frame, as none of the services were still operational. A fourth key informant was chosen because he was strongly opposed to the mainstreaming of complementary therapies into the NHS.

Prior to these interviews, I thought that the topic of this thesis would be the differences between complementary therapy service delivery in state and private settings. Afterwards, I realised that to understand variations in clinical practice, organisational aspects would need to be investigated as well.

3.5.1.2 Case site interview sample selection

Defining case site boundaries is an on-going challenge, as they may alter when new individuals, interactions or situations are uncovered (Ragin and Becker, 1992). Taking this into account, the boundaries for the cases in this study included:

- Those who established the complementary therapy service
- Past and current funders
- Past and current co-ordinators

- Past and current therapists
- Past and current users who had experienced both NHS and private treatments delivered by therapists working within the service
- Past or current evaluators of the service
- Past and current professionals from referring organisations (e.g. doctors, nurses, practice managers, receptionists)
- Past or current commissioning managers who work for the PCT where the service would be funded (if it were NHS funded)

Within the case sites, the aim of the sampling strategy was to incorporate a range of views from these categories of participants. Selection processes required more deliberation at the first site, as the service, both in terms of patient throughput and potential referrers, was much larger than at the second site. In the first site, a sub-sample of individuals within the above categories was selected, whereas at the second site, all referring doctors from the women's health clinic, practising therapists and eligible patients took part. Where selection was necessary, purposeful sampling techniques were used to identify potential candidates, in particular maximum variation and snowballing (Patton, 2002). Opportunistic sampling also occurred at site one with non-referring NHS clinicians, who were difficult to access. A key sampling criterion was professional or stakeholder background (doctor, nurse, NHS administrator, service co-ordinator, therapist, PCT manager or patient). Further criteria were:

Referral frequency

Clinicians only – ranging from lowest to highest referrers

Candidates identified from referral databases

Current or past role in developing, maintaining or delivering the service

Doctors, co-ordinators, administrators, PCT managers, therapists

Candidates identified from letters, referral databases, meeting minutes and snowball sampling

Willingness to be observed in complementary therapy consultations (see 3.5.2)

Therapists and patients

Candidates volunteered or identified by service co-ordinator (therapists) or identified by therapists (patients)

Managerial positions in PCT with current or past responsibility for complementary therapy service or decision-making influence

Range of positions including senior executives, pharmacists and public health professionals

Range of views from those known to be “positive” and “sceptical”

Candidates identified through meeting minutes and snowball sampling

Experience of treatment in both NHS and private settings by therapists observed (see 3.5.2)

Patients only

Identified by therapists

Initial contact with potential participants was made in various ways. At the first site, I used e-mail to contact doctors, nurses, practice managers, therapists and PCT managers. At the second, an informal verbal approach was made to a therapist, who then notified me that a formal letter of invitation to the head of the service would be welcome. Once the service head approved the study, I then contacted potential participants by telephone, often with extensive help from local administrators. Patients were contacted by the therapists who were observed as part of the study. The therapists asked for permission to release clients' contact details; I then sent clients a letter of invitation. These were followed up by telephone calls seeking consent. All e-mail and letter communications included information sheets about the study (Appendix A).

I had considerable difficulties identifying willing interview participants at the first case site. For example, one of the practice managers, who I was told was “enthusiastic” about the complementary therapy service, declined. Doctors and nurses, especially those who were low referrers or had not used the service, were unlikely to respond. To overcome this, I identified mutual acquaintances who made introductions and sat in waiting rooms to opportunistically introduce myself to possible candidates. I also obtained two interview transcripts from a colleague conducting a related study, with prior permission from the two nurses involved. Conversely, I had no trouble recruiting PCT managers, therapists or patients. At the second site, everyone approached for an interview agreed.

The following diagrammes detail interview participants at both case sites.

Figure 2 Case site one interview participants

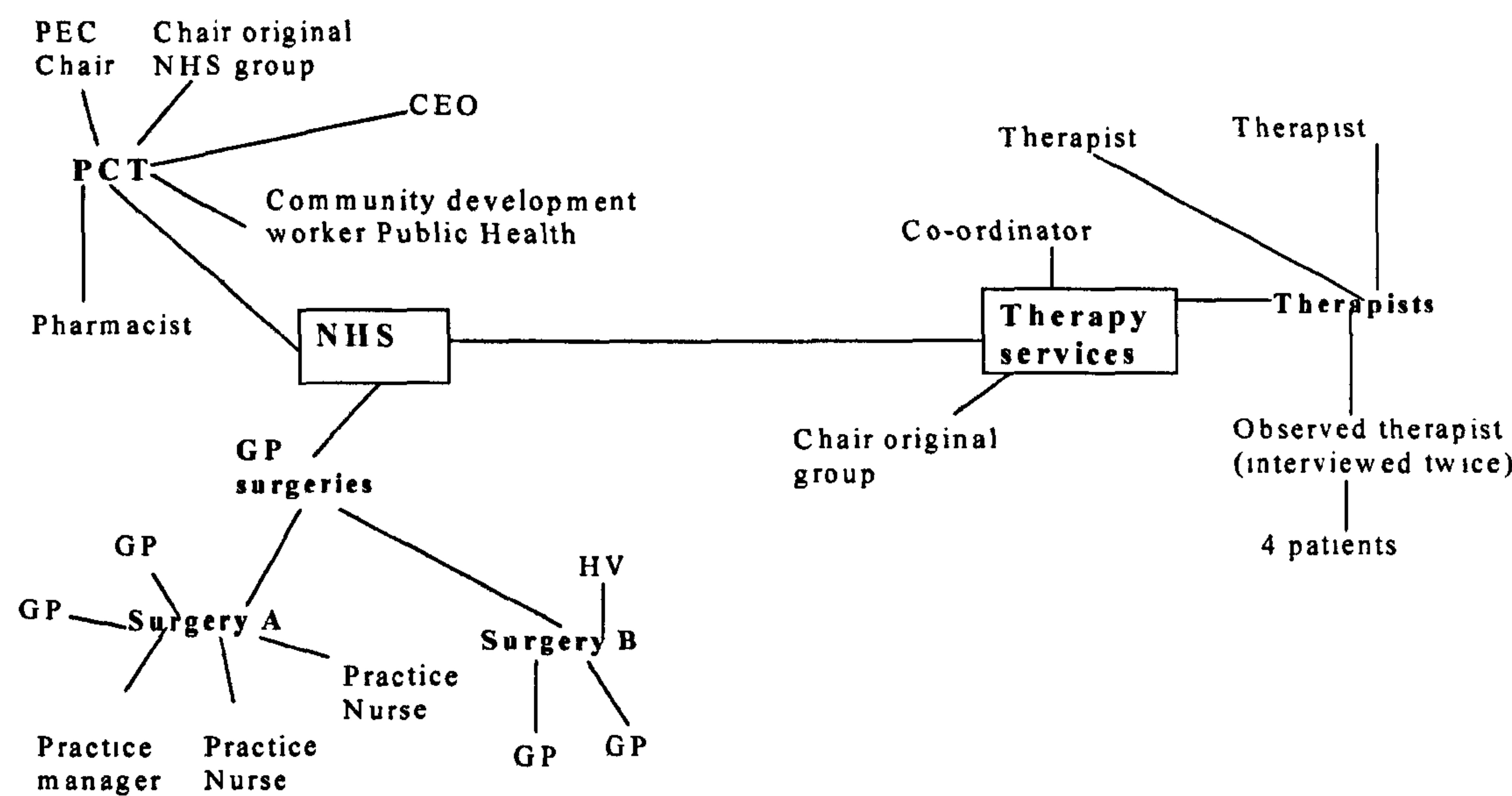
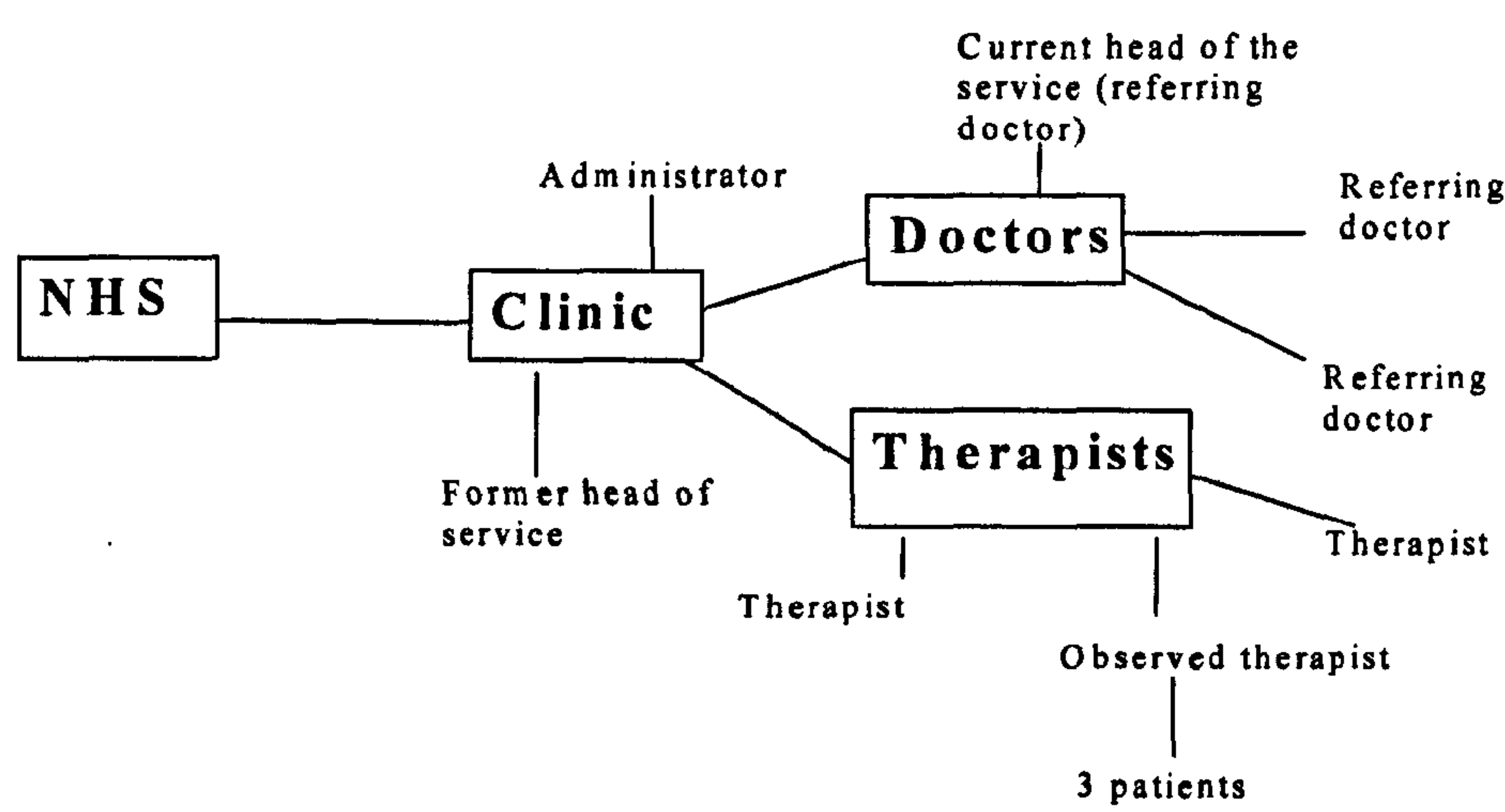


Figure 3 Case site two interview participants



In total, 23 interviews were conducted with 22 participants at the first site and 11 interviews were conducted at the second, making a total of 34 interviews with 33 participants. One of the observed therapists was interviewed formally twice; the second time was to receive feedback on preliminary interpretations and discuss aspects of the observations of consultations more fully. A second formal interview was not necessary with the second observed therapist, as our regular contact ensured that further enquires and preliminary interpretations could be discussed informally.

Qualitative researchers suggest that interviewing stop once saturation occurs and no new perspectives are revealed (Morse *et al.* 2002). Personally, I believe every individual has something unique (and usually interesting) to contribute, thus saturation can be unhelpful in defining an endpoint to data collection. Fieldwork stopped in both sites for methodological and practical reasons – firstly, because I had some understanding from a variety of perspectives (although fresh views were undoubtedly still available) and secondly, to meet self-imposed deadlines.

3.5.1.3 Conducting the interviews

For this study, semi-structured interviews were conducted, using a topic guide to steer the conversation between researcher and participant. Before each interview, I reviewed past versions of the topic guide and occasionally reviewed transcripts or documents before making further modifications to the topics covered. In this way, data collection was iterative, reflecting recent interviews, impressions, literature, observations and thoughts. Early topic guides focused on the potential of the service to induce transformational change in the NHS (“What changes would the NHS have to make to incorporate complementary medicine?”). But as fieldwork continued, this question was eliminated as the concept was too far removed from the experiences of participants in which services are initiated and cut with relative regularity without much impact on NHS professionals.

Topics regularly included were:

Personal and professional experiences of complementary therapies and complementary therapy services (all groups)

Legitimacy of complementary therapies within the NHS (all groups)

Barriers and levers to incorporation of complementary therapies within the NHS
(key informants, NHS professionals and staff, therapists and co-ordinators)

Role of evidence and evaluations in decision-making (PCT managers and clinicians)

Differences between NHS and privately funded treatments (therapists and patients).

Observed therapists were interviewed informally, both before and after observation of consultations, and any data collected were added to field notes. See Appendix B for formal topic guides.

Formal interviews lasted between 10 and 75 minutes. Of the 34 interviews, 19 were face to face and fifteen were by telephone. Face to face interviews of NHS professionals and therapists permitted observation of the setting and more clearly situated the research participant. But telephone interviews were favoured in some instances, for the practical reason of saving time, either that of the research participants or of my own. In some cases, the anonymity of telephone interviews appeared to appeal to participants, particularly PCT managers. Telephone interviews also gave the advantage of unobtrusive checking of the recording equipment.

I attempted to record all interviews, initially with a tape recorder and then with a mini disc player. One of the 34 interviews did not record at all and two others had poor recording quality, one throughout the interview and the other for the last half. For interviews with missing recordings, I noted what I could remember of the interview, as soon after the interview as possible, and sent it to the interview participant for confirmation. I transcribed 22 interviews, 11 were transcribed externally and the notes from the unrecorded interviews were word-processed. For further information on those interviewed, reasons for selection and interview details, see Appendix C.

3.5.1.4 Interview analysis

For the analysis of interview data, descriptive content analysis, otherwise known as 'thematic analysis', was chosen (Sandelowski, 2000; Caelli *et al.* 2003; Hsieh and Shannon, 2005). As an applied health services researcher this approach seemed appropriate, although it may evoke criticisms of 'generic' qualitative research. However, many studies that purport to be theoretically driven by grounded theory,

phenomenology, ethnography, feminist or narrative traditions actually use some form of content analysis (Sandelowski and Barroso, 2003).

The analytical process began while transcribing or checking transcripts for errors, as initial notes and impressions were recorded in the text. Using Atlas-ti qualitative data software, key sentences and phrases were then highlighted and given a code. Some codes emerged from previous literature (anticipated); others were generated from the data (emergent). Some quotations fell into more than one coding category. Sporadically, notes, theoretical ideas and memos were assigned to specific quotations. Related codes were cross-referenced to each other and initial themes developed. Intermittently, when a new quotation was added to a code, previous quotations within that coding category were re-read to ensure that the new quotation was appropriately assigned.

Transcripts were coded in batches according to stakeholder group and site (e.g. therapists at site one, PCT managers at site one etc.). All transcripts were then re-coded once fieldwork ended to ensure that more recently developed codes were comprehensively applied, if appropriate, to earlier data. In this second coding stage, paragraphs or larger chunks of texts were included, as the first coding stage had tended to strip the data of context. In total, over 80 codes were generated.

Although the transcripts were coded twice and read three to four times each, the analysis still felt superficial. Output generated for codes resulted in disparate chunks of text, that did not provide a sense of individual interviews as a whole, nor an understanding of the data overall. Vast volumes of data had been reduced to a series of abbreviated, isolated quotes. An intermediary stage was required.

After consulting *Getting the most from your data* (Riley, 2000), each transcript was summarised into a document noting key points and quotations organised under code headings. The summaries were printed out and read. Chunks of text were grouped into categories and broader themes. In this way, key themes were identified across the interviews, which facilitated thinking about the data in more abstract, analytical ways. Re-reading of Atlas-ti theoretical notes and memos also contributed to this reflective process. For a breakdown of codes, categories and themes, please see Appendix K.

Using an iterative approach, the interview summaries and Atlas-ti coded quotations were reviewed and themes further refined. In particular, I sought “surprises” and

disconfirmatory data (Riley, 2000). To obtain pictorial representation of the data, I drew mind maps, diagrammes and flowcharts. Data from observations and documentary sources within this study also influenced interpretations (see 3.5.4). As a final stage, I returned to the raw data and re-read the summaries to ensure that key concepts had not been overlooked, before writing up the findings.

3.5.1.5 Interview audit trail

The previous two sections may give the impression that this study proceeded smoothly from start to finish. In reporting qualitative studies, researchers often dress them up “neatly” in a way that does not accurately reflect the research process (Punch, 1986; Becker, 1998). Serendipitous occurrences are given a retrospective determination they did not possess, the process is presented as a seamless, well ordered flow and the intrinsic messiness of qualitative research is glossed over. Undoubtedly, this camouflage is a defensive mechanism on the part of qualitative researchers, who have long had to argue the rigour and value of their methods. Yet many qualitative methodologists suggest that a hallmark of good qualitative research is transparency (Lincoln and Guba, 1985; Morse *et al.* 2002). Furthermore, as qualitative data collection and analysis is an iterative process in which one feeds into the other, details on dates of interviews, transcription methods and initial transcript codings may be important in laying down an audit trail for prospective readers (Morse *et al.* 2002; Yin, 2002). Therefore to aid transparency in this study, I have provided details of the research process in Appendix C.

3.5.2 Observations

Having detailed the interview process, the next section continues with the observations of complementary therapy consultations.

Observations have been characterised as “the fundamental base of all research methods” in the social and behavioural sciences (Angrosino and Mays de Perez, 2000). Qualitative observational methods differ from experimental science observations, as they involve the systematic, detailed observation of behaviour and talk, in natural settings (Pope and Mays, 2000a). Observations indicate a belief that knowledge of the social world can be generated by observing, participating in or experiencing “real life”

settings and that the way people interact and behave is central to understanding their reality (Mason, 1996). Furthermore, ethnographic techniques are particularly useful in complementary medicine research as little is known about everyday practices and the method and topic mirror each other - both are holistic, exploring many levels concurrently (Potrata, 2005).

For many, observations automatically imply ethnography, long used by anthropologists and more recently sociologists. However, a distinction needs to be made between observations in ethnography in which the researcher “lives” amongst the group for months or even years, fully immersing him or herself in the social world under study, and observations of discrete, purposely chosen interactions as one of many data sources (Pope and Mays, 2000a). The latter approach was adopted for this study.

Observations of three types of interactions took place: 1) meetings at case site one, 2) behaviour of my medical colleagues at Bristol University and 3) complementary therapy consultations.

3.5.2.1 Observations of meetings and medical colleagues

From November 2003 until June 2007, I attended regular meetings of a research group at case site one. The focus of these meetings was on developing an evaluation, however updates on the service were regularly given. Although I was an active participant in discussions, my role was limited to offering advice about research design and implementation. I also attended a ‘Crisis’ meeting for case site 1 in January 2005. I made field notes of some of these meetings. I also kept documentation such as meeting minutes and consulted them when writing up the sections of the thesis on case site description and history of development (see 5.2).

I also opportunistically observed an incident when two medical colleagues discussed a complementary therapy intervention in my presence and displayed many of the same behaviours described in interviews and the literature. I took notes and discussed my interpretations with the colleagues involved. They gave their permission for me to include these data (see 4.6.3).

3.5.2.2 Observations of consultations

The aim of observing complementary therapy consultations in the two case sites was to uncover potential differences in the consultation process in NHS and private settings, including variations possibly not known to the therapist or patients.

Recruiting therapists to be observed was challenging. To be considered, a potential candidate had to maintain both private and NHS practices and be willing to be observed. The type of therapy practised was largely immaterial, as the setting was of principal interest. As case site selection was primarily driven by the degree of mainstreaming of the service and because few complementary therapy services operate on NHS premises, observing practitioners of the same therapy across sites was not possible.

To recruit therapists at the first site, I used the service co-ordinator as gatekeeper. After asking their permission, the co-ordinator provided me with contact details of nine service therapists whom she thought would be most interested. I e-mailed a personalised invitation and an information sheet and followed this up with a telephone call to discuss the study.

Several therapists did not want to participate for a variety of reasons such as: having insufficient numbers of private clients, their private practice was located some distance away, directors of private clinics were unlikely to consent, they had plans to leave the NHS service or were getting divorced. Two therapists were interested, both of whom agreed to observations after initial interviews. Subsequently only one, an acupuncturist, followed through. The therapist who did not was contacted on three occasions, but failed to organise any observations of consultations.

The therapist who participated in the observations was an acupuncturist whom I had met several times previously. In her late 40's, she had shoulder length hair and usually wore a black skirt, black nearly knee high boots and a brown or green shirt. She worked half a day on NHS premises, half a day each at two private clinics and a day at home. A member of the British Council for Acupuncture, she had been practising for over 20 years and had worked at the NHS complementary service at the first site since its launch. Nonetheless, she was rarely observed and had some reservations.

At the second site, the recruitment process was much easier as my first contact with the service was with the therapist who agreed to be observed. As we were previously

acquainted, I broached the possibility of her participation during an informal conversation. Subsequently, I sent her an information sheet and then telephoned her to fully explain the study. I did not ask the only other therapist currently practising at this site, a medical homeopath, if I could observe her consultations as I was principally interested in the ways in which professional complementary therapists might alter their clinical practice. I assumed, erroneously as it happened, that being a doctor, the medical homeopath would have less difficulty moderating her practice to the exigencies of the NHS.

The second observed therapist was in her mid-40's and usually wore light coloured trousers with dark shirts or jumpers. As a homeopath she qualified in the early 1990's, established her private practice and, within a few years, joined the NHS complementary therapy service when it was launched. Accustomed to observation by student and qualified doctors, she was perfectly comfortable with being observed. She was a member of the Society of Homeopaths and spent half a day in private practice and half a day in the NHS per week.

Because observation of complementary therapy consultations by a researcher is virtually unknown and, once qualified, even observation by fellow therapists is rare, I knew it would be difficult to find even one therapist in each case site willing to participate. I was aware that observing two therapists in total, and both from different disciplines, would severely limit the transferability of findings, whether researcher led or reader generated (see 3.1), but as so few observational studies of complementary therapy have previously been conducted, these data make a valuable initial contribution.

Defining the boundaries of 'private' and 'state funded' treatments was more problematic than expected. Prior to beginning fieldwork, I had assumed that treatments delivered in the NHS were state funded and those at a private clinic or the therapist's home were privately financed. As the study progressed, however, I observed a patient treated in the therapist's home but paid for by the state. After comparing this anomalous consultation with both private and NHS funded consultations, I classified it as private because the only difference between this consultation and a usual private consultation was that the patient paid a £5 contribution fee instead of £35.

In total at the first site, I observed 14 acupuncture sessions delivered by the same therapist in three different settings: the NHS (9), a private clinic (2) and her home (3). Although 14 consultations were observed, only ten different patient in total formed part of this study and they fell into three groups:

- Five were treated only in the NHS setting (one patient observed twice)
- Two were seen exclusively in a private setting
- Three were observed in both NHS and private settings (giving a total of six observations for this group)

Although possible candidates for the NHS or private only categories were numerous, only three acupuncture clients were receiving both NHS and private treatment concurrently at the time of fieldwork. All of those were observed.

At the second site, I observed 10 homeopathy sessions delivered by the same therapist in two settings: the NHS (7) and a private clinic (3). Of the seven consultations in the NHS, two were by telephone. As I only heard the homeopath speak and so obtained little data on the interaction, the telephone consultations were not included in the analysis. Clients were either NHS patients or privately funded. I did not observe any patients who had treatments in both settings because none of the clients on the current list of the homeopath met this criterion during fieldwork.

In both case sites, the therapists identified which patients would be observed. For the homeopath, this decision was pragmatic, based on who was booked for the clinics on the days I was available. She asked all clients scheduled for an appointment on the observation days and all agreed. I observed five consecutive consultations in one NHS session; and then the next day I observed three consultations at a private clinic. For the acupuncturist, the decision about which patients to observe was based initially on her interpretation of my research needs. So, the first four observations were of two women currently treated both in the NHS and privately. Although these long-term clients were selected because they met the research criteria of having both NHS and private treatments, their strong relationship with the acupuncturist may have meant that these were a particular type of consultation. So, the therapist and I agreed that I should then observe two initial NHS patient consultations. We then decided that I should observe a 'typical' full NHS clinic and so I observed four NHS patients on one morning. Following this, we turned to private patients. At the therapist's home, I saw three

private treatments (one paid for by the NHS) on two different days. The final observation was in the NHS setting and was a patient who had already been observed privately.

The therapists sought process consent from patients for the observations. At the first site, the therapist first telephoned the patients prior to their consultation to ask permission to release their contact details to me. I then sent information sheets and consent forms and followed this up with telephone calls. On the day of the consultation, the therapist reminded the clients of my presence when she greeted them. Once introduced, I asked for the signed consent form.

The consent process was less formal at the second site. The therapist greeted the client in the waiting room while I sat in the consultation room. She introduced the study and sought verbal permission for me to observe their consultation. If the client agreed (and all did), she then took them to the consulting room where I was introduced. After the consultation, I carried out the formal written consent process. Although I was less comfortable with gaining written consent after the consultation, the therapist argued that this approach took less time and the consent process was already significantly more stringent than for observations by students or doctors.

To record the settings, I drew diagrams and took digital pictures of all settings where treatments were observed. To capture the consultations, I recorded the dialogue between the therapist and patient using a mini-disc player. During some treatments, I moved around the room as this provided alternative perspectives. In addition to recording dialogue, I also took notes during the consultation detailing the behaviour of the therapist and patient, my reactions, thoughts and changes in my body. I recorded the time of every action, thought and response observed and experienced. After every observed consultation, informal interviews took place with therapists and the corresponding data added to my notes.

Although the data collection process at the two sites was the same, the process of analysis differed for reasons explained below.

For the acupuncture sessions at the first case site, fieldwork notes were typed up for fourteen consultations. I then transcribed verbatim the recorded dialogues for ten consultations. I could not transcribe four, for various reasons, including: they did not tape (2), I could not understand the accent of the patient (1) or a background whine

interfered with recording quality (1). However, I still had written notes for these consultations, which fed into the 'quantitative' analysis (see below).

In transcribing dialogue, I noted the time when each spoken interchange took place. The separate documents of field notes and tapes were then amalgamated into one document (for an example, see Appendix D). After creating this merged document, I then listened to the recording again, timing the length of pauses, noting laughter and double-checking the timing of other actions (e.g. acupuncturist washing hands or leaving the room). While listening to the recording for a third time, I annotated the merged document with thoughts or queries. This process of transcription and data familiarisation was carried out with batches of recorded consultations, the first four in November 2004, the next two in December 2004, the next three in January 2005 and the last in March 2005. As I became acquainted with batches of consultation data, patterns and suggestions of other topics began to emerge which were influenced by subsequent observations and interviews. Formal interviews with patients and therapists were interspersed with collecting and analysing observation data.

Once I had collected, transcribed and become familiar with the data from the observations, coding began. From my multiple readings of my observation notes, I developed codes, such as noise, advice and patients' integration of biomedical and complementary treatments. To deepen my understanding of these concepts further, chunks of texts from the observations and field notes relating to these and other codes, were grouped together and put into categories and broader themes. To obtain a fresh perspective, a colleague coded data from six consultations (the three patients who had been observed both in the NHS and in private settings). After considering her findings, I then re-read all of the data associated with each code, category and theme, exploring commonalities and differences across the two settings. During this stage, I also regularly shared and discussed coded interview data with the therapist and patients who had been observed. For a breakdown of the codes, categories and themes, please see Appendix K.

With observations, Agar suggests that counting the quantifiable can lend weight to qualitative findings (Agar, 1980). Within the acupuncture sessions observed at the first site, I realised that time, in particular, seemed significant. I analysed the intended versus actual length of the sessions, length of time with the needles inserted, frequency and

length of silent pauses and number of techniques used. I averaged the times and compared them across the different settings. As the field notes for the unrecorded sessions also contained these data, they were included for these analyses.

After analysing the majority of acupuncture consultation data both thematically and by counting, I re-interviewed the acupuncturist to challenge emerging interpretations. I then wrote up the methods and results. Following this, I re-read the observations, looking for anything important missed. From this process, I then had a series of theories about possible differences between treatments offered in NHS and private settings.

As I was principally looking to confirm or refute those assumptions, which centred mainly on variations in time and space, analysis of the data collected at the second site was not as extensive. While observing these sessions, I could find only 'cosmetic' differences in homeopathic treatments in the two settings. Therefore, although I recorded consultations, transcribing them verbatim to more fully explore the 'talk' in consultations did not appear to be useful. Hence, I repeated the 'counting' analysis by comparing the actual and intended length of the sessions across the two settings. I also compared prescribing decisions.

To test my preliminary conclusions further, I carried out further analyses. A matched pair of NHS and private consultations from each observed therapist was analysed in depth. In selecting acupuncture consultations, I chose the private and NHS consultations in which the therapist, the client, the condition *and* the treatment were all the same; only the setting was ostensibly different. For the homeopathy observations, no single client had been observed in both settings but I did observe first consultations for two women suffering from hot flushes; one was seen in the NHS and the other in a private clinic. These then became the selected matched pair of homeopathy consultations.

For each of the four consultations, I re-listened to the recording noting the time and the topic of conversation, activity and external noises. I also added data on these aspects from the field notes. I then entered the data into two tables, one for acupuncture consultations and another for the homeopathic consultations, and identified commonalities and differences across the consultations in the two settings. These tables are presented in Appendix E.

3.5.3 Documentary sources

Having described interview and observational data, the following section covers documentation.

Yin suggests that documentation is probably relevant to every case study topic (Yin 2003). Documentary sources provide further evidence to develop an understanding of the social world under study and inform interpretations garnered from other data sources (Mason 1996). With complementary therapy research in particular, Dew argues that documentary evidence can provide insights into political and social aspects that are not easily captured otherwise (Dew 2005a; Dew 2006). The aim of collecting documentary materials for this study was to learn about the process of service development, the characteristics of the service itself and current patterns of use. They also contributed to the selection of interview participants. In addition, they were useful in identifying possible contradictions between what was said and what was written.

Several types of documentation were available, especially at the first site. Here I was given the original “working folder” collated by the chair of the service development group. I also collected other documentation from service co-ordinators and the service website. Documentation included:

- Letters
- Minutes of meetings
- Annual reports
- Service evaluations
- Newsletters and newspaper reports
- E-mail correspondence
- Service funding bids (3 for the original service and 1 for the recently revised service)
- Output from an Excel referral database

Although I read through everything, only materials that recorded the people and processes behind the service were relevant for my analysis of this site.

At the second site, less documentary evidence was available. Specifically, a therapist, the head of the service and the administrator provided:

- A draft of the original funding bid

- A service evaluation report
- A published audit
- Extract from referral database (handwritten book entries)

All of the documentation collected at the second site informed the analysis of this site.

The following table presents the types of documentary evidence selected, the information obtained and reason for its selection.

Table 2 Types of documentary evidence and reasons for selection

Case site	Type of documentation	Information obtained	Reasons for selection
1	Letters	People working at site 1 when initial funding bid submitted	Interview sampling
1	Minutes of meetings	Members of original steering group and other committees Topics of discussion at steering group meetings	Interview sampling Mapping history of development of service
1	Annual reports	Service aims, providers, processes, users & outputs	Mapping history of development of service Describing service
1 & 2	Evaluations	Service aims, providers, processes, users & outputs	Mapping history of development of service Describing service
1&2	Service funding bids	Service aims, providers & costs, clinical evidence cited, funders priorities	Describing service Clarifying use of evidence in commissioning & mainstreaming strategies
1 & 2	Referral databases	Therapies used, referral source, numbers of referrals	Interview sampling Assessing referral behaviour of clinical study participants
2	Published audit	Patient health outcomes	Describing service

In analysing these materials, letters and meeting minutes were read and then used to identify people still available within the case site for the interview sampling frame. Alongside these, evaluations, funding bids, audits and annual reports were scrutinised to map service development and construct a précis of events. They were also instrumental in writing up descriptions of the case sites. In addition, the funding bids helped determine how clinical evidence was used in commissioning processes and initial strategies for mainstreaming.

In constructing a sampling frame of clinicians and to compare reported and actual behaviour, referral data were analysed at both sites. At the first, a spreadsheet was generated of referrals resulting in treatment from June 2001 to November 2006; this detailed name of referrer, role (doctor, nurse etc.), therapy referred to and number of patients referred. At the second site, data recorded manually from March 2004 to June 2006 were collected with name of referrer, therapy referred to and date. To identify low and high referrers, total number of referrals per referrer were counted and the proportion of total referrals calculated for each referrer.

3.5.3.1 Service evaluation reports

In addition to documentation from case sites, I collected complementary therapy service evaluations from across the country from November 2003 to June 2007 to inform my understanding about the possible impact of these type of services on health outcomes and NHS cost pressures, which I assumed (and interviews with study participants confirmed) would be key issues in the debate about mainstreaming. As many of these evaluations are 'grey literature' and therefore not easily found in database searches, a rigorous, comprehensive searching strategy was devised including:

- Contacting colleagues at the Foundation for Integrated Health, mid-Devon Primary Care Research Group and the Universities of Bristol, Sheffield, Thames Valley and Westminster as they had conducted studies themselves and/ or were well networked to identify others who had
- Contacting all members of the primary and secondary wave collaboratives of the Foundation for Integrated Health, many of whom had conducted or commissioned an evaluation

- Searching PubCAM sub-database of Medline
- Identifying potential studies from bibliographies of reports previously collected
- Hand searching issues of *Complementary Therapies in Medicine*, *Homeopathy* and *Journal of Alternative and Complementary Medicine*
- Contacting staff from the Office of the Deputy Prime Minister to locate New Deal for Communities projects where complementary therapy services might be provided
- Telephoning professional bodies
- Contacting list keepers for MYMOP and SF36 to ask for contact details of those potentially using these validated tools to evaluate complementary therapy services.

Papers and reports were included if the service was delivered in state funded primary care (with one exception) and located in the UK (with one exception). The two exceptions were included because both evaluations were carried out with the explicit aim of winning state funding for their primary care complementary therapy services (Richardson, 2001; Mulkins *et al.* 2003). Without them, a review of evaluations would be incomplete. Reports were excluded if they were evaluations of complementary therapy treatments paid for privately or delivered in secondary care, universities or charities. In total, 42 reports were collected for 33 services (Appendix F).

In analysing these, for each I noted details such as the date of the report, approach used (e.g. qualitative or quantitative), sources of information (e.g. medical records, focus groups) and details collected from each source (e.g. prescription rates, patient satisfaction). I then extracted data from evaluations reporting on health status outcomes derived from MYMOP or SF36. I chose to focus on these reports, as the inclusion of data from these standardised tools allowed me to compare across the services. Only reports that included confidence intervals, or included the data to calculate them, were included in the analyses of health outcome data. To calculate confidence intervals, I required data on number of patients included, mean difference between baseline and follow up scores and standard deviation. For two evaluations where these data were not present, I contacted the evaluators to request them. Neither

was able to furnish these data in a usable form. After conducting analyses on health outcome data, I extracted data from all evaluations reporting on NHS cost pressures such as rates of prescription, GP consultations or secondary care referrals. Once all health outcome and cost variables were extracted, I compared results across the services to assess the impact of the services. Because different therapies were being evaluated and the before and after time points varied substantially, it was not possible to carry out a meta-analysis.

3.5.4 Use of all three data sources

In collecting and analysing data from three sources (interviews, observations and documentation), I wanted to add richness and help inform different sources. But I was particularly keen to identify and explore discrepancies. We all, whether research participants or not, exhibit incongruities in words or actions. As Whyte quoted by Silverman argues

[Researchers] should recognise that ambivalence is a fairly common condition of Man [and presumably women too] - that men can and do hold conflicting sentiments at any given time. Furthermore, men hold varying sentiments according to the situations in which they find themselves (Silverman, 2001).

However, my purpose in isolating and uncovering these contradictions was not to catch study participants out or to triangulate sources to arrive at a cohesive 'truth'. Instead, by uncovering discrepancies, internal and external conflicts are revealed and the complexities of human interactions are brought to light – which may be uncomfortable. Nonetheless, in the longer term, this process could facilitate and bring about greater understanding between those holding polarised views.

However by presenting each data source independently, I have probably oversimplified what was in practice an organic, messy, creative process. Describing the iterative process of qualitative research is never easy, but the following give a few concrete examples of the way the sources were combined, compared or cross-referenced:

- Service evaluations, audits and reports were compared with interview data to explore the differences between the information produced by complementary

therapy service evaluators and the information required by NHS professionals to commission and endorse complementary therapy services

- Interview data were cross checked with minutes of meetings, service evaluations and reports to develop the histories of service development
- Interview data from patients and therapists on the differences in treatment settings, flagged up interactions and behaviour to be alert to, while conducting observations of consultations
- Funding bids and interview data were compared to learn how clinical evidence influenced the commissioning process
- Interviews were cross referenced with referral data to explore discrepancies between clinicians' espoused attitudes, reported behaviours and documented actions.

3.5.5 Challenging interpretations

I actively sought out challenges from a wide variety of perspectives to test “face validity” (Pyett, 2003) and gauge credibility (Agar, 1980) of my findings. These served a dual purpose; I received feedback about my work while simultaneously disseminating it to key individuals and organisations. On writing and re-writing thesis chapters, revised interpretations were incorporated.

For example, several individuals commented on drafts of particular chapters or papers drawn from the thesis including: the observed therapists, a PCT manager, a GP academic, a non-academic GP and staff members of the Foundation for Integrated Health.

I led seminars and workshops with:

- Sheffield School of Health and Related Research (2005)
- Penny Brohn Cancer Care centre (2006)
- Lewisham PCT (2006)
- The University of Westminster ICAM Unit (2006 & 2007)
- The Bristol Homeopathic Hospital Research Group (2007)
- Academic Unit of Primary Health Care, University of Bristol (2007)

I gave oral presentations at conferences organised by:

- York University (2005)
- The South West Society for Academic Primary Care (2007)
- The Alternative and Complementary Health Research Network (2004, 2005, 2006, 2007)

In addition, I published a paper in a peer reviewed journal (Wye *et al.* 2006) and drafted another (Appendix L).

3.6 Reflections

Having detailed the methods used to undertake this study, the next section reflects on its process. While quantitative research adopts multiple techniques to eliminate bias, in qualitative studies, there is explicit recognition that the researcher's beliefs, thoughts, emotions, presuppositions and personal history, inevitably shape the research. To clarify my own position, I am a white, middle class American woman who practised as a kinesiologist for over four years. I have used complementary therapies extensively for myself and my children. Although complementary therapies are not 100% effective, I believe that their benefits derive from changes in energy. In addition, consultation processes can also be very healing. In sum, I think complementary therapies 'work'.

But over the course of this study, my pro-complementary therapy stance has been challenged. Both professionally and personally, my networks have changed, especially since leaving my kinesiology practice in June 2006. Doctors and PCT managers now predominate. So although I am in favour of complementary therapies, I also have heard and adopted some 'mainstream' views.

In clarifying my positioning in relation to the data, regular reflexivity can be a useful tool (Etherington, 2004). To do this, I made journal entries weekly or fortnightly for nearly two and a half years and then more sporadically. These covered everything from decisions on research design to loftier musings on my changing perspectives on complementary therapies and biomedicine. Many entries were concerned with my multiple, mutating roles as a researcher and therapist.

Once influences are identified through reflexivity, some qualitative researchers attempt to minimise their effect by "bracketing" off personal factors (Ahern, 1999). But others argue that this is contrived (and impossible); instead personal influences can be employed to enrich the research (Finlay, 2002; Mantzoukas, 2004). Personal filters and

circumstances influence which research questions are chosen, which data are collected and how they are interpreted (Mantzoukas, 2004). Other researchers may access different research participants. Even if the same participants are included, the information obtained may vary. Moreover, even if the information gathered was identical, different researchers may arrive at diverse understandings. Given this, good qualitative research includes reflexivity, so that the personal lens of the researcher is better understood and validated, which enhances its trustworthiness (Etherington, 2004). The following section discusses reflections on my roles in the research process.

3.6.1.1 Role in interviews

With interview participants, I utilised several roles to gain access and establish rapport: researcher, therapist, complementary therapy user and wife of a PCT manager.

As the wife of a PCT manager, I obtained introductions to several individuals within one PCT that I was unlikely to have accessed without this personal contact. I was also able to navigate the impenetrable world of commissioning and speak their language. Subsequently, I have tried to contact PCT managers without my husband's assistance and have been rebuffed. Once access was established, I also occasionally employed the role of "researcher as intruder" (Anderson *et al.* 2005). This took the form of 'expert' - I provided the latest evidence on complementary therapy research when relevant to commissioners. This led to interesting observed interactions, which are reported in chapter 4 (see 4.6.2).

Being a complementary therapist influenced the information given during interviews. I was sometimes asked, "You're a therapist, aren't you?", before therapists expanded on a particular point, possibly pertaining to energy or the therapeutic relationship. This role also undoubtedly coloured the information received from clinicians and PCT managers, as they tended to appear more positive about complementary therapies than expected. The most common assumption made was that I was in favour of mainstreaming. Over-identification with the group studied is a common pitfall in qualitative research (Fontana and Frey, 2000). In several interviews, I attempted to clarify my position of equipoise regarding mainstreaming, but this often appeared to be disregarded.

3.6.1.2 Role in observations

Role adoption also affected the observations of consultations. Having frequently used both acupuncture and homeopathy, I was familiar with the terminology and consultation processes. I knew what to expect and when practices deviated from the norm. These experiences as a complementary therapy user also helped with rapport; several clients asked if I had had treatments myself.

In one instance at the first site, the roles of therapist and researcher melded, causing considerable confusion. In a particularly rushed morning at the NHS premises, the second consultation was with an elderly gentleman. The acupuncturist found his circumstances particularly upsetting and once the session finished, she burst into tears. I hugged her and in doing so was in therapeutic not research mode. However, once the clinic was finished, I sought to regain my research role by writing up my observation notes and debriefing with a research colleague.

This experience demonstrates how difficult it can be to remain detached in fieldwork. Ethnographic researchers describe a continuum of observer roles from complete observer to observer as participant to participant as observer to complete participant (or “going native”) (Gold, 1958; Barnes, 1992). During initial observations at the first site, I did not speak (unless directly spoken to) and tried to blend into the background. After four observations however, the acupuncturist was considering leaving the study as she found this unnerving. Accordingly, we agreed that we would speak with each other and the client at the treatment start. The therapist also began directing questions to me during treatments and several clients joined in the ensuing conversations. Towards the final observations, I found myself growing so comfortable with this more active role that I had to suppress the desire to interrupt.

At the second site, I was permitted to return to a less active role, only speaking to patients and the therapist at the start and end of consultations. In most cases, I was completely forgotten, even though in the NHS setting, I was directly opposite the patient. However, after the third client at this site, the homeopath asked if I had identified anything energetically. Wanting to be helpful, I passed on my energetic impressions. As this type of exchange could have influenced prescribing decisions, I felt uncomfortable and so this was not repeated.

3.6.1.3 Effect of my presence on the consultations

At both sites, the therapists noted that my presence made consultations more “intense”. Observations at the first site were especially affected. During the early observations, the acupuncturist initially chose clients she knew well because she was self-conscious. My presence also modified the questions asked. For example, sexuality was not raised, although the therapist later disclosed that with one client she believed this to be relevant. Clients also reported some discomfort. They did not volunteer more socially ‘unacceptable’ physical symptoms. Another client was acutely embarrassed when the therapist asked her to remove her bra. The client looked at me and refused - all three of us were highly aware of the impact of my presence.

As observations continued however, this therapist became happier and more relaxed. Clients who were observed a second time reported disclosing previously concealed information. A high point was when the acupuncturist and client commented on my “lovely chi”, saying that my presence had actually enhanced the treatment.

In general, clients appeared to take their cue from the therapist; so clients observed towards the end of fieldwork at the first site and in the second were much more comfortable. At the second site, with the exception of one client who refused to look in my direction, all the clients appeared minimally affected by my presence. Interestingly, the mini disc for this consultation did not record.

3.7 Conclusion

This chapter began by outlining my epistemological and ontological positioning and continued by discussing case study methodology. I then discussed the data collection and analysis processes for the three sources used for this study. It concluded with a short reflective section on the impact of my role on the interviews and observations of consultations. The next chapter presents the first of three results chapters.

CHAPTER 4 Evidence

4.1 Introduction

The key question of this chapter is: What is the role of evidence in mainstreaming complementary therapy services? This is a macro level question as the issue of evidence affects the provision of all complementary therapy services offered in the NHS, regardless of geographical location. It is consistently a considerable hurdle in convincing clinicians and commissioners of the value of complementary therapies, and so an ideal topic for this thesis. But what evidence persuades commissioners? Is the commissioning of NHS complementary therapy services really reliant on evidence or are other factors at work?

To explore this, I have drawn on several sources of data from my fieldwork and wider reading including:

- Interviews, particularly with key informants and NHS professionals, including Primary Care Trust (PCT) managers, doctors and nurses
- Documentary sources such as:
 - Evaluations of complementary therapy services from across the United Kingdom
 - Referral databases
- Observations of:
 - PCT meetings
 - Medical colleagues at Bristol Medical School
- Wider reading including
 - Qualitative studies exploring decision-making behaviour amongst clinicians
 - Quantitative studies of surveys of NHS complementary therapy and counselling provision
 - Literature debating appropriate methodologies for complementary therapy research
 - Systematic reviews of acupuncture and homeopathy

- The Cochrane Collaboration database, specifically searches on homeopathy, osteopathy, chiropractic, acupuncture, herbal medicine and counselling

From these data sources, several themes were identified and developed in relation to the role of evidence in mainstreaming complementary therapies. These themes are detailed in the table below. For detailed description of how these themes were developed, see 3.5.1., 3.5.2. and Appendix K.

Table 3 Key themes, data sources and process of derivation of theme for macro level topic of the role of evidence

Theme	Data sources contributing to theme development	Process of derivation of theme
Paradigmatic tensions between medical and complementary therapy models of health and illness	Literature including qualitative studies with NHS professionals and the complementary therapy community and literature on methodologies for complementary therapy research Interviews with study participants	Reading of wider literature Thematic analysis of study interviews
Rhetoric on evidence based decision making	Interviews with study participants The House of Lords (HoL) report and the Department of Health (DoH) response Department of Health white and green papers	Thematic analysis of study interviews Reading of 'evidence' sections of DoH and HoL documents
'Reality' of evidence available	Interviews with study participants Service evaluations Systematic reviews on acupuncture and homeopathy	Thematic analysis of study interviews Analysis of service evaluations & systematic reviews
Discrepancies between rhetoric and reality	Interviews with study participants Observations of NHS	Thematic analysis of study interviews Analysis of

Discrepancies between rhetoric and reality (cont)	meetings and medical colleagues Literature including qualitative studies of decision making, systematic reviews and surveys of NHS provision of complementary therapies and counselling	observations of NHS meetings and medical colleagues Reading of literature
Other influences on decision making	Interviews with study participants Observations of NHS meetings and medical colleagues Literature on decision making	Thematic analysis of study interviews Analysis of observations of NHS meetings and medical colleagues Reading of literature

This chapter begins by exploring the paradigmatic differences between biomedical and complementary therapy models that lead to difficulties in gaining consensus around the best way to measure changes in health and illness. I continue with a discussion of the rhetoric around science and evidence based medicine and its prevalence at national policy and local decision-making levels. This is followed by an exploration of what types of evidence counts for gatekeepers, including summaries of the evidence from service evaluations and the clinical evidence for two therapies, homeopathy and acupuncture, as these are the therapies I observed in the case studies. I will not, however, enter into the debate of whether scientific approaches such as the double blind randomised controlled trial are appropriate methodologies to gauge the value of complementary therapies as this has been covered thoroughly elsewhere (Vickers *et al.* 1997; Richardson, 2000; Barry, 2003; Barry, 2006; Ernst, 2007). In comparing the rhetoric on evidence based decision making with the reality of the behaviour of NHS professionals, I continue by detailing discrepancies demonstrated by study participants and in NHS service provision, suggesting that scientific evidence may not play as major a role in decision-making as the public discourse would lead us to believe. Other influences such as informal networks are also powerful influences on professional views.

4.2 Paradigmatic tensions between medical and complementary therapy models of health and illness

Although contested, we live in an age whereby the prevailing belief is that scientific methods are most apt to lead us to “truth”. As Fuchs argues

The privileged stance of scientific knowledge reflects the sacred role science plays in the public discourse of modern society and culture. Ever since the Enlightenment equated science with societal progress and moral emancipation from tradition and superstition, science has come to be viewed as the paradigm for all rational practice...The label “scientific” lends special credibility and authority to knowledge claims and discursive practices and social groups try to mobilise science in support of their interests (Fuchs, 1992).

Other forms of knowing, such as personal experience and intuition, are given less credence than conclusions arrived at through logical, standardised, “objective”

processes devised and executed by the mind. Despite strong critiques of this amongst particular individuals and groups, (Klein, 2000; Druss, 2005; Goldenberg, 2006; Sweeney, 2006) in Western cultures we live in a time whereby science dictates what is valid and, more importantly for complementary medicine, what is not. As Cant and Sharma argue, those brandishing the badge of science can make claims of objectivity and rationality, which often “disguise moral judgments” (Cant and Sharma, 1999).

But science struggles when it comes to complementary therapies. Much has been written about why, such as the difficulties in identifying appropriate ‘placebos’, the methodological challenges in designing trials for complex interventions about which little is known of the ‘mechanism of action’ and the importance of defining and measuring patient generated outcomes (Richardson, 2000; Verhoef *et al.* 2002; Mason *et al.* 2002; Glik, 2003; Weatherley Jones *et al.* 2004). Recently, an international group of complementary therapists have proposed ‘whole systems research’ as a way forwards in evaluating complex interventions such as complementary therapies. (Verhoef *et al.* 2005) Although I did not specifically ask questions about the difficulties of conceptualising and measuring the non-material in interviews, nonetheless study participants volunteered their views.

The difference in the paradigm is about how it works. You know, and why it works. And that's what they will not accept, because they're working with chemicals and genes and all the rest of it. They're working with materials. They're working with stuff. And we're working with spirit and energy. And that's where the paradigm clashes [sic]. (Key informant, homeopath, BJ, line 181)

I don't know quite what point in history it happened, but there's been a disintegration between understanding and respect for things you can't see over those things that you can see and analyse. So until the biomedical model actually accepts that there are forces in nature and people that are non-material, then I don't think they will find it very easy to integrate because that is a major schism between the two schools of thought. (Key informant, osteopath and healer, CG, line 15)

A doctor concurred.

Well, I've been educated in the very medical model of disease so when I look at a treatment subjectively I can think - well chiropractors I can see that in my medical model that would work. If you have back pain, if you have neck pain, if you manipulate the neck or you align it then something is going to happen. Reflexology,

to quote one example, no matter how many people talk to me about the energy lines and those sort of things, it just doesn't fit in with my understanding of illness and disease. (Doctor, BM, line 32)

Because the immaterial, energy or chi is difficult to measure, there are challenges to applying traditional scientific methods to test the value of complementary therapies. In essence, there are two possible ways to frame the effectiveness question.

The first is 'Is it working?', specifically is this particular intervention bringing about this pre-determined outcome? Randomised controlled trials, as a methodology, provide answers to such a question that the more scientifically minded feel confident in. But another way to frame the question is to ask 'Is there any benefit?' This is a much broader question that can be answered satisfactorily through patient accounts and encompasses change on any level – emotional, mental, even spiritual, as well as physical. The subtle difference between these two questions underpins much of the debate about evaluating complementary therapies because what is deemed as appropriate methodology and “robust” evidence, depends on your worldview. Nonetheless, as Richardson points out, if complementary medicine is to become mainstreamed, then providing evidence of effectiveness in a way that is palatable to those with a scientific bent undoubtedly plays a role (Richardson, 2000). This has been made abundantly clear in recent policy initiatives discussed in a theme in the next section, 'rhetoric on evidence based decision making'.

4.3 Rhetoric on evidence based decision making

4.3.1 Policy rhetoric calling for evidence based decision making

Since the mid-1990s, evidence based medicine discourse (and ideally) practice has steadily diffused into Western healthcare systems. Although “conventional medical practice is characterised by the overenthusiastic adoption of unproven interventions while continuing to offer services demonstrated to be ineffective” (Muir Gray, 2001) resulting in 30-40% of patients not receiving care according to present scientific evidence (Grol and Grimshaw, 2003), the thrust of government policy and initiatives is to disseminate and promote research based practice. For example, guidance from the National Institute for Health and Clinical Excellence (NICE) aims to encourage clinicians to practise in an evidence based way. A positive review from NICE may

further mainstream acceptance, as demonstrated by the recent enthusiasm for cognitive behavioural therapy (Mayor, 2006). To date, no complementary therapy has undergone a NICE review, but the necessity for this has been debated (Franck *et al.* 2007; Colquhoun, 2007).

In reviewing treatments, interventions must demonstrate therapeutic and cost effectiveness as well as allaying concerns about safety. The importance of meeting these criteria was stated clearly in the House of Lords Select Committee report on complementary medicine. In asking commissioners to identify key factors in their decision-making about provision of complementary medicine, they found that 85% cited therapeutic effectiveness and 75% cost effectiveness – the two most commonly named criteria - while safety did not even rate in the top ten (House of Lords, 2000). Undoubtedly, these views influenced the committee's recommendation in that the production of evidence was a precursor to inclusion within the NHS.

In our opinion any therapy that makes specific claims for being able to treat specific conditions should have evidence of being able to do this above and beyond the placebo effect. This is especially true for therapies which aim to be available on the NHS and aim to operate as an alternative to conventional medicine, specifically therapies in Group 1 (House of Lords, 2000).

Group 1 therapies, also known as the 'Big 5', included osteopathy, chiropractic, homeopathy, herbal medicine and acupuncture. As a contender for mainstream status, government discourse agreed that "strong" evidence would be needed for any of these to become available on the NHS (Department of Health, 2001a). But neither the Select Committee nor the Government defined what "strong" evidence was, thereby leaving this open for individual interpretation. Furthermore, the government added a qualification:

However in the final analysis it must be for the NHS clinician or healthcare practitioner with lead clinical responsibility for the individual patient to judge whether, when and how an individual patient could benefit from the use of a particular therapy. Wherever possible the patient should be actively involved in this process and in any agreed plan for his or her treatment or therapy (Department of Health, 2001a, response to recommendation 5).

So, the national policy is that if a complementary therapy is to be mainstreamed into the NHS, there must be evidence of therapeutic and cost effectiveness for the specific

condition for which effectiveness is claimed. But it is not clear how much or what type of evidence is needed and the final judgment about whether a particular individual should receive a complementary therapy rests with his or her “lead clinician”, who invariably is a doctor. Furthermore, the government acknowledges that the patient should be “actively involved” in the decision-making, but does not state how or the extent to which patient preference should influence clinical practice.

This being the situation, the perspective of clinicians, especially doctors, about the validity of complementary therapies and consequently the views they express to patients, are crucial. Furthermore, clinicians’ attitudes are doubly important with recent policy initiatives devolving commissioning powers (e.g. practice based commissioning, enhanced services, choose and book), thereby enhancing the clinicians’ role as gatekeeper still further. How they, and PCT managers who are responsible for commissioning decisions, manage the potentially competing tensions of commissioning, evidence based practice and patient preferences is important in exploring the mainstreaming of complementary therapies into the NHS. This will be discussed throughout this chapter.

4.3.2 Local rhetoric calling for evidence based decision making and patient choice

The government line is that evidence of effectiveness is essential. So how pervasive is this discourse at a local level? In interviews at my first case study site, it was widespread amongst clinicians from both nursing and medical backgrounds.

We're all very evidence based now, aren't we? So we have to kind of back things up so. (Nurse, M, line 33)

Some of them [other doctors] were quite negative about having [complementary therapy service] here in the first place because of the supposed lack of evidence. (Doctor, BM, line 90)

PCT managers also talked about the importance of evidence.

My hunch would be that we would be supportive of it [complementary therapy provision in the NHS], if there is reasonable evidence that it provides benefit over the current provision. (PCT manager, RA, line 39)

Moreover, although acknowledgement was made that much biomedical practice suffers from a lack of clinical evidence, the production of clinical evidence for particular complementary therapies was identified as a prerequisite to mainstreaming.

I think we've got to be very careful to tease out those things which we think are effective and those that are not. Now a lot of medicine suffers from not. We don't know whether a lot of medicine's effective. But I think we should be pursuing the effectiveness line so that we are very careful about not having the more wacky end of complementary medicine being developed and taking people for a ride really. But [we] are prepared to develop it where it looks like a good buy. (PCT manager, BC, 21)

This suggests that evidence is so important that it is the filter by which commissioners decide which therapies could be considered for mainstreaming; research evidence is the tool used to discriminate between bogus and genuinely therapeutic interventions. Indeed, I found the evidence rhetoric was so omnipresent that that in interviews even complementary therapists, who are often perceived as being unscientific, claim the term.

I believe what I do is science, Lesley. Every time I give a remedy or I make up a theory about what type of remedy a patient needs based on the evidence, I'm performing an experiment. So, I think what I do is science. (Key informant, homeopath, BJ, line 179)

Furthermore, therapists are fully aware that evidence is a pre-requisite to mainstream funding.

They're always asking for research and proof, which is what the osteopath council are trying to put more energy into now as well, because they want to go more integrated and they want it to be more recognised, which is happening more and more all the time now. (Key informant, osteopath, JP, line 414)

Thus, evidence discourse has seeped through to influence the language of clinicians, commissioners and even complementary therapists. But some are uneasy.

I sometimes feel that we kind of go too far into sort of science and evidence based. I mean if it works and people benefit and they feel better you know what more proof do we need? I think as long as it's a safe practice, you know it's safe, then do you need the evidence? You know my feelings are probably no you don't. If people benefit and feel better and can cope with what ever is going on then, perhaps you don't need the evidence. (Nurse, M, line 191)

Therefore, for some, as long as an intervention is perceived as safe, patient experience might weigh more than research evidence. Other studies have also found this; nurses and complementary therapists are more likely to prioritise self-reported patient benefits (Beattie *et al.* 2007). But in this study, doctors from the second site also expressed views favouring the importance of patient experiences.

Evidence has been forced on us and become very much the thing to work by, but I'm much more patient orientated and particularly in [specialist area] there's a lot of grey areas, which is very difficult to work within evidence-based medicine. (Doctor, SP, line 183)

One doctor, in particular, explicitly framed the tension between being evidence based or patient centred, in terms of a trade off between being “hard” and scientific or being “soft” and patient focused.

You know I'm not really a hard, sort of scientific doctor. I like the softer approach to dealing with people and it [complementary therapies] appealed to me. (Doctor, WW, line 37)

This doctor continued by recounting that her patient focused approach clashed within the prevailing culture and, in her view, led to the eventual loss of her managerial position.

I was managing the services that were being devolved into PCTs and then I went to work for the PCT for a short time in the commissioning side. But that was where some of the problems came because I always put patients' care first and if you're in commissioning in the PCT level, I couldn't. I couldn't do it. (Doctor, WW, line 27)

Thus, although governmental policy regularly highlights the importance of patient centredness, at local level, the exigencies of evidence may be prioritised when complementary therapies are under consideration. This became apparent in an interview with a PCT Chief Executive. After nearly fifty minutes of discussion about the mainstreaming of complementary therapies, much of which concerned the importance of evidence, my penultimate question was the role of patient choice. With some embarrassment, he replied

Yes, I think, it's a very good point you raise about patient choice and I haven't. That's very interesting, because I should have thought of patients' choice. (PCT manager, BC, line 105)

So although patient centred care and evidence based medicine are both government flagships, with regard to complementary therapies, the local rhetoric suggests research

evidence is prioritised, although there is some unease with this amongst those describing themselves as more “patient centred”. Given that the call for evidence is so widespread, what sort of evidence about complementary therapies is convincing?

4.3.3 What evidence counts?

There are many types of evidence, but for the purposes of this study I have concentrated on two formal sources: 1) service level evaluations and 2) randomised controlled trials, which are often called clinical evidence. These were most commonly named by study participants as sources of useful information on therapeutic and cost effectiveness. In briefly outlining the differences between the two, the first often involves qualitative or mixed methods and there is no control group, whereas the second obtains information through comparing a randomly allocated intervention against a placebo or a control group. The first explores the impact of a service and the second tests effectiveness of a therapy. A crucial difference is that trial methodology strives for objectivity by eliminating bias and prioritises the group effect, while service evaluations emphasise the importance of experience, whether patient or clinician, in all its messy subjectivity. So which type is more likely to sway clinicians and commissioners?

In general, clinicians and PCT managers from the first site said during interviews that clinical evidence would persuade them of the therapeutic effectiveness of complementary therapies.

- *I think we need evidence of effectiveness from randomised controlled trials not anecdotes or prescriptions [sic] of people's experience if we want to know what works. (PCT manager and doctor, YW, line 22)*

In terms of introducing a service you've got to have an evidence base and then a needs assessment and evidence base. And within our proposals template now we have a section on evidence needs assessment and evidence base. So, we need to feel that we have taken some advice on whether an intervention is effective. (PCT manager, BC, line 33)

Others saw the value of both scientific evidence and evaluations.

You've got to gather that evidence but without having the service set up somewhere, you can't gather the evidence, you know? --- like a

chicken and egg which, how do you get the evidence without running the service? (Nurse, PN, line 109)

Others were less convinced of the usefulness of evaluations.

[Evaluations] don't actually provide evidence that the intervention itself actually works. All they'll do is demonstrate patient satisfaction in one way or another. (PCT manager, RA, line 20)

No study participants mentioned that service level evaluations on their own would be enough to convince them of the therapeutic validity of complementary therapies.

I have to say that I'm not a Public Health expert but I know our Public Health Director looked at the report [of an evaluation of a local complementary therapy service] and was not particularly impressed by the rigour of it. The people who were questioned seemed to be a very small number. There were claims that everybody who used the service thought it was marvellous. And when you looked at it, the numbers were so small. And not necessarily the most needy [sic] groups if you like, sort of more the worried well. It wasn't robust enough for Public Health. It certainly wouldn't have passed muster for her. So, if it wouldn't pass muster for her, then I don't think it would pass muster for anyone else. (PCT manager, CB, line 36)

Hence, evaluations may not convince clinicians and PCT managers of therapeutic effectiveness. However, those who had had commissioning responsibilities within the PCT said they were more likely to find service evaluations valuable if they included data on how the complementary therapy service had alleviated NHS cost pressures, particularly secondary care referrals, clinician consultation time or prescription costs.

Osteopathy presumably that is more of one where people get referred to outpatients, or not outpatients, what do you call it? Physiotherapy.... Then you could say well it saved this many visits to a physiotherapist in a hospital which you know.... If you could demonstrate people who had been on medication for depression or mental health problems that any of these therapies had reduced their reliance on the medication then that would be good. (PCT manager, CB, 43)

Commissioners want this information because they can then determine whether a particular service increases overall costs (add on) or replaces the need for other services (instead of). This information is not obtainable through trials looking at therapeutic effectiveness alone, although those that include an economic evaluation do offer some insight. However, locally, commissioners are concerned to identify and maximise “instead of” services and evaluations can provide these data. This is particularly

important because the projected NHS debt for the financial year 2006-2007 was £835 million pounds (www.theyworkforyou.com 5.1.07 accessed 21.3.07). As a PCT manager from the first site stated,

Well, the PCT is in a very difficult financial position at the moment, I'm sure you know. We have what's called a local delivery planning group, which is the sort of first sound bite where bids for funding would go. And the criteria we use will be - how much money is this going to save? Basically, it has to pay for itself in terms of hospital admissions or even make savings over and above the cost of running the service. For anything that costs more money, it's very difficult to get it through unless it's one of our very top priorities in terms of meeting some of the criteria like targets that we have to meet that we're being measured on and being judged on, things like reducing emergency admissions. (PCT manager, CB, line 32)

Hence, complementary therapy services not only have to be cost neutral, so the savings generated cover the costs of the service itself, but they potentially may have to demonstrate an appreciable impact on reducing service costs elsewhere, ideally in the hospital sector.

We can only invest if we find things we can disinvest in. Now that mainly is disinvesting in hospital interventions, whether it be outpatient clinics or diagnostics...And if we can reduce those because we're doing an earlier intervention in primary care, then we can for the first time probably take money out of the acute hospital system and bring it into the community. The new arrangements with payment by results, which does mean that if we don't send the patient elsewhere we don't pay for them, mean[s] that we can actually take the money out. So we do have some choices... It could be from referrals to orthopaedic outpatients. It could even be from looking at the skill mix within a GP practice that says actually people with back problems are taking up this amount of GP time, this amount of practice nurse time and actually by having an osteopath clinic in this practice or maybe across several practices we can reduce the amount of GP time by one session a week or an amount of practice nurse time. (PCT manager, BC, 29)

Many evaluators of complementary therapy services do not collect information on the impact of the service on prescription costs, secondary care referrals and primary healthcare professional consultation rates (Wye *et al.* 2006). However, the importance of collecting and reporting these data was identified in a Delphi exercise carried out by Jane Wilkinson at the University of Westminster. Experts, including practitioners,

academics and NHS professionals were asked to identify the most important ingredients in devising a robust evaluation report for a NHS complementary therapy service. The resulting guidelines on BESTCAM reports recommend including data on NHS cost pressures as well as information on health outcomes (Wilkinson *et al.* 2004b). However, in related work not reported for this thesis, I explored the link between evaluations and funding, finding that in many cases, production of data that showed a positive impact on NHS cost pressures were not enough, on their own, to result in NHS funding of the complementary therapy service (Wye *et al.* 2006) (Appendix L).

So in summary, what type of evidence counts? In detailing findings for the theme of ‘rhetoric on evidence based decision making’, my study participants say that trial methodologies can provide persuasive evidence of therapeutic effectiveness, which is convincing to both NHS commissioners and clinicians, while service evaluations offer useful information on the impact a service has on NHS cost pressures, which is of particular interest to commissioners. To fund complementary therapies through the NHS, decision makers ideally need both.

Thus having explored the theme ‘rhetoric on evidence based decision making’, what information do clinical evidence and evaluations provide, particularly about health outcome benefits, costs and savings impacts? The next section discusses the theme of ‘reality of evidence available’.

4.4 The ‘reality’ of evidence available for complementary therapies

Before continuing, I would like to highlight that when faced with the same set of results, people may differ substantially in their interpretations. As Northrup puts it,

There is actually no such thing as completely objective data. Cultural bias determines which studies we believe and which we ignore. No one is immune to this behaviour (Northrup, 1998).

This point will be expanded later in this chapter, but suffice it to say, in interpreting evidence, I am just as prey to my prejudices as anyone else – as are you the reader. In being explicit about my own perspective, although I have doubts about the cost effectiveness of complementary therapies, I strongly believe they are therapeutically

beneficial. Thus, my tendency is to credit positive results and discount negative ones. However, to compensate for this acknowledged bent, I may have been overly critical in interpreting the service evaluations and academic research presented below.

4.4.1 Service evaluations

The reasons for conducting an evaluation may vary. For instance, some may report progress to current funders. Others aim to improve aspects of service delivery and still others are devised to attract potential new funders. Regardless of their explicit (or implicit) objectives, evaluations measure service effectiveness not therapeutic effectiveness. There are many approaches to this.

In reviewing the 42 reports with data collected on 33 complementary therapy services, the majority of services used quantitative (21) or mixed methods (9), but three services were evaluated using qualitative methods alone. Three of the studies were randomised controlled trials; three were action research studies, one of which was within a mixed methods evaluation, but the majority were either audits of outcomes or surveys.

The most common methods employed were patient health status questionnaires (15), data extraction from referral forms (12), patient satisfaction questionnaires (10) and costings of the service (9). In terms of health outcomes, some studies relied on locally developed self-reports (either retrospective or before and after) but many used validated health outcome measures such as MYMOP (8) or SF36 (7). Five studies also contained data on NHS cost pressures with information on impact on prescription, GP consultation rates or secondary care referrals. Information on health status and NHS cost pressures is presented next.

4.4.1.1 Health status information provided from service evaluations

The SF36 is a questionnaire which asks the patient to assess their health status in eight areas: physical functioning, role limitations due to physical health difficulties, role limitations due to emotional problems, pain, vitality, mental health, social functioning and general health. It is a well-validated tool that has been found to be appropriate for use in the NHS (Garratt *et al.* 1993).

Seven evaluations used the SF36, but only six reported their results. Administration was before treatment (either at referral or first treatment) and follow up time points were variable, as two administered the questionnaire at the final session (Impact, Glastonbury), one four months after baseline (GP purchasing) and another six months after baseline (Tzu Chi). Two others were probably administered before completion of treatment, as follow up for Lewisham occurred at the last session or three months after baseline (whichever came first) and for Liverpool occurred eight weeks after the first session.

The therapies offered also differed. The GP purchasing pilot provided only osteopathy and chiropractic and had the largest number of returns (n=312). The Lewisham (n=179) and Impact (n=54) services almost mirrored each other as they offered acupuncture, homeopathy and a manipulation treatment (osteopathy at Lewisham and chiropractic at Impact). Liverpool (n=69) and Glastonbury (n=224) provided five therapies; both offered osteopathy, acupuncture, massage and homeopathy while Liverpool also provided counselling and Glastonbury offered herbal medicine. The Tzu Chi service (n=212) offered over eight different therapies.

In comparing across the services, four aspects consistently have confidence intervals which do not cross zero. They are: role physical, social functioning, pain and vitality. However, although there is evidence of benefit, there is variability in the range of clinical significance. For example, the scores with the largest change were found with pain. The GP purchasing pilot scores showed the greatest impact (95% CI 20.8 to 26.7), closely followed by Impact (95% CI 19.7 to 34.7). A less clinically important difference was found with vitality. The least change appears to have been made with role emotional, mental health and general health. However, although there is little change, there also appears to be little evidence of harm as the largest negative 95% confidence interval was -4.1 (Liverpool). Overall, the Liverpool evaluation had the poorest outcomes, which perhaps is because the 'after' questionnaires were administered eight weeks after the treatment started, which in many cases was while treatment was still on going (Appendix G).

Comparing the results of the data from the Lewisham and Impact services is interesting, as the same type of therapies were offered, although the Lewisham evaluation had over three times as many returns. In looking at the two, scores for role

physical, social functioning and vitality were similar which suggests that the therapies of acupuncture, homeopathy and manipulation treatments have a marked impact on role physical, with a more modest influence on social functioning and vitality.

In exploring the effectiveness of services, the GP purchasing pilot offering osteopathy and chiropractic, the Impact service offering chiropractic, homeopathy and acupuncture and the Lewisham service offering acupuncture, homeopathy and osteopathy consistently produced the highest scores across all SF36 aspects. This suggests that these particular services were highly effective.

Another health status measure frequently used was MYMOP. MYMOP stands for Measure Yourself Medical Outcomes Profile and is a self-reported patient questionnaire. In this questionnaire, patients identify their first and second priority symptoms that “bother” them the most and an activity that is affected by those symptoms, which they then score on a Likert scale of 0 to 6 from as “as good as it can be” (=0) to “as bad as it can be” (=6) in the past week. They also rate their wellbeing on the same scale. A MYMOP profile score combining those four scores can be created. A change in score from 0.5 to 1 is considered to be clinically significant (<http://www.hsrb.ac.uk/mymop/faq.htm> accessed 22.3.07). In a comparison of SF36 and MYMOP, MYMOP was found to be more sensitive to change (Paterson, 1996).

Although eight evaluations included MYMOP data, only six included enough details to be included in this analysis. All six offered homeopathy with two specialising only in that therapy (Coventry [n=80] and North Kirklees [n=65]). Sheffield Menopause clinic (n=54) additionally provided aromatherapy and reflexology, while Impact offered acupuncture and chiropractic (n=85). Get Well UK provided acupuncture, aromatherapy, massage and osteopathy as well as homeopathy. CHIPs provided over ten different therapies.

All administered the baseline questionnaire at referral or initial treatment. Follow ups were consistently administered at the final treatment. Not all evaluations reported all MYMOP aspects, however. North Kirklees only reported data for the first symptom and wellbeing, while Get Well UK only reported the MYMOP profile score. With the data available, I can report confidence intervals from five evaluations for the first symptom and wellbeing, from four evaluations for the second symptom and activity and from three evaluations for MYMOP profile.

Overall, the first symptom showed the greatest change followed by the second symptom. Scores from the Coventry and Impact services showed the most improvement. For the first symptom, Impact recorded the highest level of change (mean difference 2.6, 95% CI 2.3 to 3.0) closely followed by Coventry (mean difference 2.5, 95% CI 2.08 to 2.9). For the second symptom, these two services reversed places with Coventry showing the greatest change (mean difference 2.5, 95% CI 2.0 to 3.0) followed by Impact (mean difference 2.4, 95% CI 1.9 to 2.9). For activity, again Coventry demonstrated the greatest change (mean difference 2.4, 95% CI 2.0 to 2.9) and Impact came second (mean difference 2.0, 95% CI 1.5 to 2.4). But for wellbeing, Impact had the greatest score (mean difference 1.7, 95% CI 1.3 to 2.1) with North Kirklees (mean difference 1.6, 95% CI 1.2 to 2.0), rather than Coventry, demonstrating the next greatest level of improvement. Neither Coventry nor Impact reported profile scores and so Sheffield Menopause clinic showed the greatest improvement (mean difference 2.1, 95% CI 1.5 to 2.7) (Appendix G).

All the services showed an impact in terms of patient reported health status. The average change in score was consistently greater than one (the accepted upper threshold for clinical significance) and in some cases it was closer to a two and half point difference. This suggests that the services had a substantial effect on health status. Although I recognise that there is considerable debate about clinical significance, in my own private practice as a therapist, I found that usually MYMOP scores needed to change by two points for clients to appreciate any difference. This was the case for the first and second symptoms for all services except CHIPs, but less change was noticeable for activity and wellbeing.

4.4.1.2 NHS cost pressure information provided by service evaluations

Whereas it is possible to measure health outcomes from these evaluations, data on NHS cost pressures is sketchy. Furthermore, they are difficult to compare since different evaluations used different methods to calculate savings. However, all accessed their data from GP records.

For prescription rates, four evaluations (Coventry, St. Margaret's, Get Well UK and Newcastle) used the denominator of service users, while another (Glastonbury) used

the denominator of total number of prescriptions. Timing of data collection also varied. Two evaluations collected data six months before and after treatment (Coventry and Newcastle), two 12 months before and after (Glastonbury and St. Margarets), one 16 months before and 9 after (Impact) and one 24 months before and an average of 5.7 months after (Get Well UK).

Six evaluations reported cost data, but two were of especially poor quality (Newcastle and St. Margaret's) as they took a sub-sample population (unclear as to how selected), extracted medical records and then extrapolated their findings across the entire study sample, which resulted in highly impressive figures.

Although data on cost pressures from these evaluations are not trustworthy, overall for prescriptions, three out of five evaluations reported that these services reduced prescription rates substantially. The Newcastle evaluation reported a 39% reduction, Glastonbury a 45% reduction and Coventry a 57% reduction. The services at Impact showed no effect on prescription rates (95 % CI -0.09 to 0.16). The evaluation of Get Well UK found that costs for prescriptions for referred conditions increased after treatment (mean pre-treatment £3.24, 95% CI £1.80 to £4.80 and mean post-treatment £3.75, 95% CI £1.74 to £6.49), although records for only 33 people were included (Table 4).

Table 4 Changes in prescription rates identified in service evaluations

Evaluation	N	Data extraction timepoints	Change	95% Confidence Interval	Total savings in pounds
Coventry	49	6 months before & after	28 people reduced or stopped (57% reduction)		2807.30
Glastonbury	41	12 months before & 12 after	88 prescriptions in total reduced to 48 (45% reduction)		382.47
St Margarets	24	12 months before & 12 after			8944
Newcastle	70	6 months before & 6 after	41 people stopped/reduced (39% reduction)		520
Impact	28	16 months before & 9 after	Change of 0.04 (SD 0.35)	-0.1 to 0.1	
Get Well UK	33	24 months before & average 5.7 months after	Pre treatment mean £3.24 Post treatment mean £3.75	£1.80 to £4.80 £1.74 to £6.49	

Six evaluations reported on the impact of the complementary therapy service on GP consultation rates. Reported rates of reduction ranged from 31% (for two evaluations) to 71%. Two evaluations provided data to calculate confidence intervals, with Coventry indicating a modest change (mean difference 1.2, 95 % CI 0.4 to 2.0) while Impact results suggested there was no change (mean difference 0.1, 95% CI -0.1 to 0.4). Data from the Get Well UK evaluation suggested that consultation rates actually increased from a mean different of 0.5 (95% CI 0.4 to 0.7) pre treatment to a mean difference of 0.8 (95% CI 0.6 to 1.1) post treatment. To put these data into context, the average consultation rate for females in the UK is five per year and for males it is three.

(<http://www.clinicalanswers.nhs.uk/index.cfm?question=354> accessed 16.6.07).

Table 5 Changes in GP consultation rates identified in service evaluations

Evaluation	N	Data extraction timepoints	Base-line mean	Follow mean	Change?	95 % Confidence Interval
Coventry	49	6 months before & after	6.4	5.3	1.2	0.4 to 2.0
Impact	28	16 months before & 9 after	-----	-----	0.1 (SD 0.6)	-0.1 to 0.4
Glastonbury	41	12 months before & after	3.1	2.2	31% reduction	
St Margarets	24	12 months before & after	3.1	1.0	71% reduction	
Newcastle	70	6 months before & after	5.7	4.0	31% reduction	
Get Well UK	33	24 months before and average 5.7 months after	0.5	0.8		0.4 to 0.7 0.6 to 1.1

Glastonbury and St. Margaret’s provided data on secondary care consultations, but the data are so different (and dubious in the case of St. Margaret’s) that they are impossible to interpret. The Get Well UK evaluation found that the number of referrals and tests to secondary care were reduced (mean 1.4 pre treatment to mean 0.7 post treatment), as were their corresponding costs (mean £112.64 pre treatment to £64.72 post treatment), in the average of 5.7 months after the intervention ceased.

Two evaluations provided health outcome data as part of a randomised controlled trial; one also provided cost data.

The Lewisham service provided homeopathy, acupuncture or osteopathy, delivered by professional therapists for over 20 different conditions. Seven hundred and sixty two people were randomised into a pragmatic trial, with a waiting list control (Richardson, 2001). Of those, 179 people in the treatment group and 151 in the control group completed both baseline and final treatment SF36 questionnaires. Results suggest a moderate to strong improvement for:

- Role emotional (mean difference 20.7, 95% CI 11 to 30.3)
- Role physical (mean difference 19.9, 95 % CI 11.2 to 28.6)
- Social functioning (mean difference 15.7, 95% CI 8.4 to 22.9)
- Pain (mean difference 14.9, 95% CI 8.5 to 21.2)
- Vitality (mean difference 12.2, 95% CI 7.7 to 17.6)
- General health (mean difference 10.8, 95% CI 5.5 to 16)
- Mental health (mean difference 9.3, 95% CI 4.1 to 14.4)

Only physical functioning showed no change (mean difference 6.0, 95% CI -1.0 to 13.1).

The Randomised Osteopathic Manipulation Study (ROMANS), which was a pragmatic randomised controlled trial to assess a GP osteopathy service, did not suggest such positive outcomes (Williams *et al.* 2003). Two hundred and one patients with neck and back pain were randomised into two groups: usual GP care or osteopathy. The groups were stratified by location of pain (neck, upper back, lower back or combination). 72 people in the control group and 70 in the osteopathy group completed a questionnaire at two months; 72 people in the control group and 63 in the osteopathic group returned a questionnaire at six months. The primary outcome measure was the Extended Aberdeen Spine Pain Scale (EAPS). Secondary outcome measures included the short form McGill Pain Questionnaire (SMPQ), the SF-12 health profile and the EuroQol index of health utility.

The results at two months suggested an improvement in score for EAPS (mean difference 5.3, 95% CI 0.7 to 9.8) and SF 12 mental health (mean difference 6.7, 95% CI 2.7 to 10.7) for the osteopathy group, but all other measures suggested there was no change. At six months, the previously recorded improvement in EAPS disappeared (mean difference 4.4, 95% CI -1.5 to 10.4), but the SF 12 mental score improvement persisted (mean difference 5.5, 95% CI 1.0 to 9.9). None of the other measures suggested any change.

The outcome on the SF12 mental score was the only one that showed both short and long term improvement for osteopathy. However, the authors argued that the weak or absent association found in the other measures could be due to them being “less responsive” to change. They concluded that primary care osteopathy improved short-

term physical and longer-term psychological outcomes. My interpretation of these data is less generous. There is weak to non-existent evidence from this study to support the premise that GP osteopathy is better than usual care for neck and back pain, but mentally people feel better.

In addition, as part of the ROMANS study, data on health service utilisation were extracted from medical records from 101 people in the usual care group (93%) and 86 in the osteopathy group (95%). In looking at NHS cost pressures, the researchers considered a variety of measures, including GP contacts, primary health care team contacts, investigations, prescriptions, consultant contacts, A&E contacts, in-patient episodes, physiotherapy contacts, aids and appliances. They determined costs for any condition, as well as specifically for spinal pain. They found a difference between groups in mean total costs of almost £22 (95% CI -£159 to £142) (these costs include the costs of the osteopathy treatment), but the confidence intervals suggest there was no relationship between provision of the osteopathy service and decreased costs. However, a between group difference of £65 in mean costs for spinal pain alone did demonstrate an association (95% CI £32 to £155), suggesting that the osteopathy service reduced costs due to spinal pain (Williams *et al.* 2004).

There are many possible reasons why the Lewisham and ROMANS studies resulted in such different outcomes. Perhaps, as suggested by the ROMANS authors, their choice of outcome tools were not sufficiently responsive to change and the SF36 tool used in the Lewisham study is more sensitive. Therapists might contend that the difference in the studies suggests that treatments delivered by professional therapists instead of biomedically trained practitioners give better results. Others might argue that this demonstrates the methodological challenges in carrying out randomised controlled trials of complex interventions like complementary therapies and other methodologies should be used. Still others could point out that the wide confidence intervals of the ROMANS study suggests an underpowered study. Regardless, the evidence is relatively inconclusive.

So in summary, in looking at complementary therapy service evaluations, data from validated health outcome questionnaires suggest that these services do have an impact on self-reported health status. SF36 scores indicate the most substantial change is for pain, but role physical, social functioning, vitality and mental health aspects also

demonstrated improvement. MYMOP scores suggest that the greatest impact these services had was on the first and second symptoms of primary concern, both of which indicated change of clinical significance. So in examining before and after health outcomes for evaluations without a control group, NHS complementary therapy services appear to be making a difference to the patient. However, pragmatic trials challenge this interpretation, as one study suggested substantial improvement and the other did not.

The impact of these services on NHS cost pressures is much less clear. The data are so poor, it is hard to make a judgment. In many cases, the methodology is suspect or key information, such as standard deviations and confidence intervals, are missing. In the more robust evaluations of GP consultation rates (Coventry, Impact and Get Well UK), one found no change, one found a reduction and the other found an increase. Only two evaluations (Impact and Get Well UK) gave sufficient data for prescription rates finding no change and increased rates post treatment respectively. There are perhaps many reasons why this might be so. For example, one participant in my study mentioned that although benefiting substantially from acupuncture, she was still seeing her GP regularly to pass on updates about her health status. Perhaps other patients also behave in this way.

Having explored the evidence offered by evaluations, in the next section I will go on to explore the clinical research evidence for two complementary therapies, acupuncture and homeopathy. These two therapies were chosen as they were practised by the therapists in the observational part of this study.

4.4.2 Information provided by clinical evidence

It is beyond the scope of this study to do justice to the entire clinical evidence base for either acupuncture or homeopathy; selection is necessary. In meeting the aim of giving a brief summary of the clinical evidence for each therapy, I have consulted well respected sources such as the NHS Centre for Reviews and Dissemination and the Cochrane Collaboration. I have also included those reviews and studies that are well known within the complementary therapy research community, as their absence would be glaring omissions. By such selection criteria, many illuminating studies may be overlooked, but my purpose is to provide an overview of key research.

4.4.2.1 Acupuncture

The clinical trial evidence base for acupuncture has grown substantially, however the results depend on the condition studied. Published in 2001, the most recent Effective Healthcare Bulletin for acupuncture concluded:

Acupuncture appears to be effective for postoperative nausea and vomiting in adults, chemotherapy-related nausea and vomiting and for postoperative dental pain. Current evidence suggests that acupuncture is unlikely to be of benefit for obesity, smoking cessation and tinnitus. For most other conditions, the available evidence is insufficient to guide clinical decisions (NHS Centre for Reviews and Dissemination, 2001b).

Cochrane Collaboration reviews, which are often perceived as the gold standard, concur with this, suggesting that the clinical evidence is good for the use of acupuncture for chemotherapy induced nausea or vomiting (Ezzo *et al.* 2006), post operative nausea and vomiting (Lee and Done, 2004), idiopathic headaches (Melchart *et al.* 2001) and neck disorders (Trinh *et al.* 2006) and low back pain. (Furlan *et al.* 2005). In their review of the acupuncture evidence base, Birch and colleagues concluded that results for migraine, low back pain and temporomandibular disorders were considered positive by some and mixed by others, for fibromyalgia, osteoarthritis of the knee and tennis elbow, the results were promising but more research was needed; and for chronic pain, neck pain, asthma and drug addiction, the evidence was inconclusive (Birch *et al.* 2004).

In 2004 in a major study funded by Health Technology Assessment, Vickers *et al.* found that people having acupuncture experienced 22 fewer days of headaches annually, used 15% less medication, made 25% fewer visits to GPs and took 15% fewer days off sick. They concluded that acupuncture services for headaches should be considered by NHS commissioners (Vickers *et al.* 2004).

In conclusion, the scientific evidence for acupuncture is growing but patchy, and studies tend to focus on the benefits of needling for specific conditions. In some areas, reviews of the evidence are positive, in others negative and for most inconclusive. Furthermore, little is known about impact of acupuncture treatments on NHS cost pressures. I will now turn to the clinical evidence base for homeopathy.

4.4.2.2 Homeopathy

Kleijnen and colleagues carried out one of the first systematic reviews of homeopathy in 1991. Of 105 trials, 81 had positive results and 24 were negative. They concluded that the results were promising, but the methodological quality of the trials was poor. They also noted that the mechanism of action was implausible (Kleijnen *et al.* 1991). Another influential review was published by Linde and colleagues, a few years later in 1998. They found that the clinical effects of homeopathy were not attributable to placebo alone (Linde *et al.* 1998).

Several other reviews have been carried out since, but the focus has been as to whether homeopathy is superior to placebo, rather than evaluating homeopathy for specific clinical conditions (Linde *et al.* 2001). This raises another issue. Testing for specific conditions is a biomedical approach. Homeopaths tend not to treat a single symptom but the “picture” as a whole, including a range of physical, mental, emotional and spiritual conditions. Hence, the perennial problem of this approach is that it might be valid for some biomedical professionals but not homeopaths. Nonetheless, some condition specific trials and subsequent reviews, have been carried out in homeopathy, most notably Cochrane Reviews for asthma (McCarney *et al.* 2003), influenza (Vickers and Smith, 2006), dementia (McCarney *et al.* 2002) and induction of labour. (Smith, 2003). All of these reviews found insufficient high quality trials have been performed to determine the effectiveness of homeopathy for any of these conditions.

Given the persistent lack of trial data, the NHS Centre for Reviews and Dissemination (CRD) guidance for clinicians on homeopathy is unsurprising. They concluded:

The evidence base for homeopathy needs to be interpreted with caution. Many of the areas that have been researched are not representative of the conditions that homeopathic practitioners usually treat. Additionally, all conclusions about effectiveness should be considered together with the methodological problems of the research. There is currently insufficient evidence of effectiveness either to recommend homeopathy as a treatment for any specific condition, or to warrant significant changes in the current provision of homeopathy (NHS Centre for Reviews and Dissemination, 2002).

In updating this review of the evidence base for homeopathy in 2007, Kayne found that three of the six meta-analyses conducted in homeopathy since 2002 demonstrated

that the benefits of homeopathy were beyond placebo, but more evidence was needed (Kayne, 2007).

The most negative (and well known) meta-analysis of homeopathy recently was conducted by Shang and colleagues. They used sophisticated statistical techniques to compare both biomedical and homeopathic treatments concluding

Biases are present in placebo-controlled trials of both homoeopathy and conventional medicine. When account was taken for these biases in the analysis, there was weak evidence for a specific effect of homoeopathic remedies, but strong evidence for specific effects of conventional interventions. This finding is compatible with the notion that the clinical effects of homoeopathy are placebo effects (Shang et al. 2005).

This study generated a storm of controversy in both mainstream mediums (e.g. www.guardianonline.co.uk and BBC News broadcasts such as the Today programme) and academic journals. Most famously Richard Horton, editor of the Lancet, declared “the end of homeopathy” (Horton, 2005b). Meanwhile supporters of homeopathy were scrutinising the study and identifying methodological flaws (Peters, 2005; Kiene *et al.* 2005; van Haselen, 2005). This led to the scenario anticipated by Vandenbroucke published in the same issue of the Lancet as the meta-analysis:

Thus Shang and colleagues arrive at a class judgment about homeopathy that will be gladly accepted by many who always thought homeopathic evidence was contaminated. Others will claim that this analysis amounted to data dredging (Vandenbroucke, 2005).

So overall, the evidence for homeopathy is inconclusive because of methodological problems, the paucity of high calibre trials and the inherent paradigmatic tensions between the homeopathic and medical understanding of disease and mechanisms of action. Although research into homeopathy continues apace, for many there is insufficient evidence to extend the provision of homeopathy within the NHS. For the ordinary clinician, this creates a situation in which little guidance is available (Linde *et al.* 2001).

In summarising the evidence on the therapeutic effectiveness of acupuncture and homeopathy, I have suggested that the evidence for acupuncture is good for a few conditions, developing towards favourable in others, poor for some and inconclusive for most. In general, the evidence base for homeopathy (in terms of meeting

biomedical criteria) is less developed, as fewer condition specific trials seem to exist. Furthermore, debates on the ‘mechanism of action’ have displaced the development of homeopathy research much more so than for acupuncture. In addition, acupuncture and homeopathy research are dogged by methodological challenges and poor quality research. I have also pointed out that interpretation of the evidence is not value free.

4.5 Discrepancies between rhetoric and reality

Having explored the theme of ‘the reality of evidence available’ by discussing the evidence for complementary therapies from two sources (service evaluations and clinical evidence, specifically acupuncture and homeopathy), I will now go on to argue that although the official public discourse at policy and local level designates “strong evidence” as the arbitrator of NHS mainstreaming, in practice clinical evidence may play a smaller role. This will develop the theme of ‘discrepancies between rhetoric and reality’. In particular, I will develop the following points:

- NHS complementary therapy services have been established despite the lack of clinical evidence.
- Doctors, who state clearly that clinical evidence is needed before complementary therapies are available in the NHS, nevertheless refer when such services are made available.
- Herbal medicine has one of the best evidence bases, yet of the Group 1 therapies it is the least prevalent within the NHS.
- Other therapies, such as counselling, have made much more substantial progress within the NHS, despite limited clinical evidence.
- While claiming to prioritise clinical evidence, NHS professionals appeared to rely more on what they believed, than what they knew, to be true about complementary therapies. For example, few study participants were certain of either the extent or strength of clinical evidence on complementary therapies, or where to find it.

These points are expanded below.

4.5.1 Services are set up in the NHS despite lack of clinical evidence

Although the spread of NHS complementary therapy services is embryonic, nonetheless a few have been established, despite the lack of clinical evidence. Interestingly, this absence can actually be used as a lever in establishing new services. In both case sites in this study, the instigators argued that the lack of evidence was a compelling reason for service provision.

It was really difficult trying to say to them, this is why we're making a pilot project so we can do that research and we can hopefully gain some facts and figures from this, to actually then move on. (Co-ordinator, MD, line 285)

[Participant was asked what advice she would give to others thinking about establishing a NHS complementary service.] Building some research into it, research from the service delivery point of view but research into the clinical point of view as well. Maybe they might be combined but I think if you can do that, then at least you can justify it. Do it on the basis we did. Look at it and see if it is working. If it isn't working, what's the point of carrying on with it? But also build up a basis for saying- look it does work and we can show it works. (Doctor, WW, line 147)

Not only are NHS complementary therapy services established despite a lack of clinical evidence, but in some cases the lack of clinical evidence forms part of the rationale for their provision.

4.5.2 Doctors refer despite lack of clinical evidence

In addition, once complementary therapy services do exist, doctors, who espouse the evidence based rhetoric, refer despite the lack of scientific proof. For example, a steering committee member from the first case site recalled during an interview the lukewarm reaction the proposed service got from a particular doctor when they held initial steering meetings.

A: We didn't get much response from the health professionals. We did have one doctor from the surgery come along...And she was quite anti it from the beginning.

Q: And do you remember what her reasoning was?

A: Basically not knowing enough about the therapies and whether they work or whether it would work. (Co-ordinator, MD, line 41)

Four years later, I interviewed this same doctor and found she still believed there was little evidence and appeared indifferent to the service.

There wasn't a great deal of evidence at that time. I don't know if there is. If you look at the studies there still isn't a great deal of hard evidence of the efficacy of complementary therapies. (Doctor, HC, line 15)

Yet interestingly, in comparing her behaviour reported during interview with her actual behaviour derived from the referral database from this site, this doctor was the third highest referrer of twenty-four doctors in total, accounting for 10% of the overall referrals to the service. So, despite her long held conviction that good clinical evidence should precede the mainstreaming of complementary therapies into the NHS, in practice she regularly referred to therapies where she believed evidence is scarce. This is of course not true across the board, many doctors who require evidence do not refer because of the lack of evidence and their words and actions are congruent. But this particular doctor, who displayed a discrepancy between rhetoric and reality, was an interesting example of what may also be common – doctors who call for clinical evidence refer nonetheless for other reasons.

4.5.3 Herbal medicine and the manipulation therapies

A further factor that casts doubt on the extent to which clinical evidence is the arbiter of access to the NHS is that the relationship between robust clinical evidence and degree of mainstreaming is tenuous at best. If clinical evidence really is crucial, then we would assume that the complementary therapy with the strongest scientific evidence base would be most prevalent within the NHS. But this is not the case.

As of the summer of 2007, the Cochrane Collaboration has published over 35 reviews of herbal medicine. Over ten have found positive results for conditions such as benign prostate hypoplasia, bronchitis and chronic venous insufficiency. More suggest that herbal treatments may help (a few are elevated to “promising”), but generally, reviews conclude that more high quality research is needed (www.cochrane.org last accessed 25.7.07). Because of the extensiveness of trial data on herbal medicine, Professor Ernst, co-author of the *Desktop Guide to Complementary Therapies*, has stated that herbal medicine has the greatest evidence base of all complementary therapies, with the most systematic reviews demonstrating therapeutic effectiveness (Ernst, 2003). Yet a national follow up

survey of NHS complementary services showed that the proportion of GP surgeries offering herbal medicine was much lower than for other therapies. For example, in 2001 only 2.7% of GP practices offered herbal medicine as compared with those offering acupuncture (33.6%), osteopathy or chiropractic (23%) or homeopathy (21.1%) (Thomas *et al.* 2003a). Furthermore, in looking at which therapies grew the most within the NHS between 1995 and 2001, osteopathy and chiropractic provision increased over 300%. Access to herbal medicine, on the other hand, grew by 80%, but in real terms provision only increased from 1.5 to 2.7 of GP practices surveyed (Thomas *et al.* 2003a).

Osteopathy and chiropractic are amongst the most popular therapies offered in the NHS, yet as of March 2007, only three Cochrane reviews of manipulation therapies have been carried out (Gross *et al.* 2003; Hondras *et al.* 2005; Proctor *et al.* 2006), two of which found there was not enough evidence to either support or refute manipulative therapies for dysmenorrhea or asthma (Hondras *et al.* 2005; Proctor *et al.* 2006) and one of which found good evidence of benefit for mechanical neck disorders (Gross *et al.* 2003). There are no Effective Healthcare Bulletins for manipulative therapies and some systematic reviews have found the evidence was inconclusive (Astin and Ernst, 2002; Assendelft *et al.* 2003; Ernst and Canter, 2006). However, more recently, their evidence base is believed to be improving (Ernst *et al.* 2007). But despite the lack of conclusive evidence, osteopathy and chiropractic have thrived in the NHS, while herbal medicine has made infinitesimal inroads.

This less enthusiastic uptake of herbal medicine in the NHS was also demonstrated on the ground in one case site. When interviewing a member of the steering committee member at the first site, I asked which therapies were not acceptable to GPs. He replied:

Part of us [wanted] herbal remedies but then people thought that was a bit too soon really to do all that.... I think that was one, one of the ones that we said to the GPs you know what about herbal remedies? And he wasn't quite sure on that. (Co-ordinator, MD, line 521)

So despite the GP representatives on the steering committee insisting that clinical evidence should be the main criterion for the provision of particular therapies, herbal

medicine, which has a more substantial evidence base, was not selected for NHS provision.

4.5.4 The case of counselling

Another example of this mismatch between rhetoric and practice is exemplified by counselling. Much of its proliferation pre-dates the production of clinical evidence on counselling.

In 2001, a national survey found that about half of all GP practices offered access to counselling (Mellor Clark *et al.* 2001). Published in the same year were an Effectiveness Matters bulletin (NHS Centre for Reviews and Dissemination, 2001a) and Department of Health guidelines on counselling (Department of Health, 2001b). The following year a Cochrane Collaboration review was published (Bower *et al.* 2002), which was revised in 2006 although results remained the same. Findings from these three highly respected sources were similar:

- Counselling resulted in improvements in health outcomes up to six months following treatment (standardised mean difference between counselling and 'usual care' -0.28, 95% CI -0.43 to -0.13, n=772, 6 trials) but not for eight or more months (standardised mean difference -0.09, 95% CI -0.27 to 0.10, n=475, 4 trials) (Bower *et al.* 2002)
- There was no clear cost advantage to the NHS
- Much more research was needed as the Effectiveness Matters bulletin and the Cochrane Review only contained seven trials.

So, over half of all GP practices offered access to counselling, before reliable sources published their reviews of the evidence. Furthermore, the actual number of trials contributing to their recommendations was small. In addition, the evidence for improvement was modest and limited to the short term. This suggests that counselling has flourished despite the lack of robust evidence of therapeutic effectiveness. When I recently put this to Nancy Rowland, the Head of Research at the British Association for Counselling Practitioners and co-author of the Cochrane Review, she agreed wholeheartedly. Although doubtless, the production of good quality evidence helps and in the past five years much more research on counselling has been carried out.

A further irony is that although the Cochrane review for counselling found only modest benefit (standardised mean difference -0.28, 95% CI -0.43 to -0.13, 6 trials), the Cochrane review for mechanical neck disorders found much stronger evidence for the manipulative therapies (standardised mean difference -2.73, 95% CI: -3.30 to -2.16, 13 trials). Yet still counselling is much more widespread within the NHS than osteopathy or chiropractic. To say that there is an inverse relationship between strength of evidence and uptake in the NHS would be overstating the case. Nevertheless, in looking at herbal medicine, the manipulative therapies and counselling, it would appear that clinical evidence of therapeutic effectiveness is only one of many factors mitigating acceptance within the NHS.

4.5.5 NHS professionals may rely on what they believe, rather than know

My questioning of the position of clinical evidence as the gatekeeper to the NHS deepened, as I gradually realised during fieldwork that many participants were not familiar with the evidence on complementary medicine. Often statements with NHS professionals in interviews were qualified with “I think” or “my impression is”. For example,

Well my impression is that there is a lot of evidence for acupuncture and chiropractor and things like that. (Doctor, BM, line 28)

I think the evidence is it's patient satisfaction even if there isn't health effectiveness. (PCT Manager, BC, line 41) (emphasis mine)

As I began to explore this, I became curious to learn if others knew the research literature. So, I modified the topic guide to include a question on whether and where they accessed information on clinical evidence for complementary therapies. I soon realised this was rather challenging. Some clinicians sidestepped the question, usually by discussing the lack of evidence in complementary therapies in general. A PCT manager was more forthright and admitted that he relied on what was presented to him, but did not often go directly to original sources. Another PCT manager reeled off a list, including several well known sources. Surprised by his obvious knowledge when thus far I had encountered sheepish looks in response to this question, I enquired further and learnt that he disseminated NICE guidance throughout the organisation and as

such a significant part of his job involved keeping up to date with research. A doctor at the first site also appeared much more informed, but this was because she had an academic research post and was a member of a NICE expert panel.

So many clinicians and PCT managers in this study were not familiar with the research literature on complementary therapies, but their prevailing opinion was that, with some exceptions, there was little clinical evidence.

I think the lack of evidence has probably been the downfall of complementary medicine. (Doctor, WW, line 239)

I think the evidence base is lacking for a lot of it, particularly with homeopathy. But some things do work, however, for example the use of aromatherapy in the hospice, chiropractic in certain circumstances. (PCT manager, RA, line 12)

The belief that the clinical evidence for complementary therapies is poor and/or nonexistent may be reinforced by lack of knowledge of where to find it. This particular finding emerged while observing a Professional Executive Committee (PEC) meeting on complementary therapies. PEC members include senior PCT managers, such as the Chief Executive, Director of Finance, Director of Public Health, Director of Commissioning and various primary healthcare representatives. The aim of the committee is to regularly review existing services. About twenty minutes into the meeting, a woman came into the room, sat beside me and introduced herself as the Deputy Director of Public Health. She said she had recently been made the PCT lead for complementary medicine. She wanted to familiarise herself with the evidence on complementary therapies and was seeking advice on where to access it. What made this exchange particularly interesting was that in interviews with PCT managers, they stated that they took guidance on the evidence in general (and about complementary therapies specifically) from the Public Health Department.

So I think there's a lot around training, probably particularly getting the public health community behind this and saying actually this is a good buy, we should be doing more of it. Because they're the ones we tend to go to for looking at effectiveness in particular, interventions and which ones we should use. (PCT manager, BC, line 85)

So if the Public Health lead for complementary medicine is not sure where to obtain clinical evidence on complementary therapies, and the Public Health department is responsible for feeding that information to the rest of the commissioning agency, then

it is debatable whether the existing clinical evidence on complementary therapies has much chance of finding its way to the right people.

Perhaps to some extent, the Deputy Director of Public Health and others struggle to identify sources of clinical evidence on complementary therapies, because so little permeates the usual channels. As one PCT manager in my study highlighted, just as there is a hierarchy of types of evidence, there is also a hierarchy of evidence sources.

And I suppose it's a question of who you trust as a source. The places I trust as a source would be Clinical Evidence, the Drugs and Therapeutics Bulletin, the Therapeutics Initiative which is a Canadian equivalent, NICE, the HTA, places like that. (PCT manager, RA, line 12)

Another study participant, who was a clinician, identified a different set of good quality sources.

A: Cochrane reviews are about the only things I really trust.

Q: What is it about Cochrane reviews that means you really trust [them]?

A: The methodology. They are done to strict methodological criteria, which is kind of policed by the Cochrane Review group. I also trust SIGN guidelines and the NICE [guidelines] (makes a so-so sign with her hand). (Doctor, SS, line 71)

Interestingly, even though this particular clinician is a contributor to Clinical Evidence, mentioned by the PCT manager quoted previously, she did not cite it as a trustworthy source.

When I mentioned these sources to other interview participants, it was pointed out that apart from the Cochrane Collaboration, they rarely included information on complementary therapies. This may in part be due to publication bias. In comparing the publication of homeopathy trials in mainstream and complementary medicine specific journals, a study found that nearly two thirds of the trials reported in conventional journals were negative, compared to 30% of those reported in complementary therapy journals. Interestingly, this publication bias did not extend to systematic reviews or meta-analyses, as positive and negative findings were equally well reported within each (Caulfield and DeBow, 2005). One assumes that if negative homeopathy trials are more likely to be reported in mainstream journals, this may be true for other complementary therapies. So if the mainstream press produces a steady

drip of negative studies, with the occasional explosive negative meta analysis (Shang *et al.* 2005), beliefs in the ineffectiveness of complementary therapies are probably reinforced.

Furthermore, even if a conscientious individual did manage to find a paper on a complementary therapy intervention from a trusted mainstream source that (unusually) was positive, there is the lens of personal interpretation. Individuals accept the evidence that supports the beliefs they already have and reject that which refutes them (Bell, 2005). Thus, understandably, there is a lack of consensus about which complementary therapies are perceived to have a “strong” evidence base. For example, one study participant stated during interview that the evidence for homeopathy for some conditions was convincing, (PCT manager BC) while another felt “sceptical”. (Nurse AL) A third agreed that the evidence for homeopathy was dubious but was much more enthusiastic about acupuncture.

Acupuncture for example there is just so much evidence emerging for its effectiveness both anecdotal/ patient descriptive and research based that it would be foolish not to accept it really. (PCT manager, RA, line 12)

A fourth called both acupuncture and homeopathy “hocus pocus”. (PCT manager YW) In this study, I found that views about which complementary therapies had the “strongest” evidence base varied.

In summary, many commissioners and clinicians revealed that, although they are not familiar with the clinical evidence on complementary therapies, they believed it was probably not robust. But without much direct personal knowledge, they were not sure. If they attempt to redress that knowledge gap and turn to their most trusted sources, they find scarce information about complementary therapies and the little which is discovered tends to be negative, which is likely to concur with their prior beliefs. This then perpetuates the consensus that complementary therapies are ineffective. It is a rather vicious circle.

Of course, it could be argued that those who believe there is little convincing scientific evidence about complementary therapies are correct, and during fieldwork, I was surprised by how often study participants’ views were “right” (by which I mean agreed with my own interpretation), despite their limited access to the research literature. But, on further reflection, I realised that I simultaneously hold seemingly contradictory

beliefs about the evidence on complementary therapies, all of which were echoed by study participants. To illustrate, I agree that there is little scientific evidence for acupuncture (compared with the evidence for statins), there is good scientific evidence for acupuncture (for example compared with my own discipline of kinesiology) and there is good scientific evidence for acupuncture for some conditions (for instance, compared with homeopathy, which has less condition specific research). I have come to realise that the degree to which an intervention is found to have “good evidence”, depends as much on the other evidence base under comparison. This further complicates decreeing an evidence base as “strong”.

I present these findings not to browbeat clinicians and commissioners into feeling guilty for not scrutinising the clinical evidence personally. But rather, I make them to untangle rhetoric from reality. Various government policies and local rhetoric from key gatekeepers have stated that robust scientific evidence is the key to inclusion of complementary therapies in the NHS, yet in practice, behaviours contradict this and other complicating factors such as personal interpretation is ignored. Little breaks the cycle of negative reinforcement that complementary therapies are ineffective. So what else influences perspectives on complementary therapies? In the next section, I will develop the theme of ‘other influences on decision making’ and I will argue that another trusted source - that of tacit knowledge gained from informal, unofficial networks - can influence commissioners and clinicians just as powerfully.

4.6 Other influences on decision making

4.6.1 Patient and prior clinical experiences

In the absence of clinical evidence, patients’ experiences help some clinicians form perceptions of useful interventions. For example, a practice nurse from the first case site and a doctor from the second commented

...things like acupuncture and the Buteyko method 'cos anecdotally I've got people who, you know, in the past, not here but in the past who have tried it and you know have found themselves to be so much better. But you have to go on the evidence. (Nurse, PN, line 53)

I don't think you can't just ignore your own experience of things. Okay, perhaps that doesn't go down particularly well these days. If

I hand out these particular tablets and most people get better on them, you carry on doing that. Or if you see one person who has a bad reaction to something then that is what you tend to remember. It perhaps is wrong but at the end of the day you are dealing with an individual person. (Doctor, WW, 111)

Interestingly, both clinicians seem to feel somewhat uneasy in proposing that patient experiences have validity. The first qualifies her views by concluding “but you have to go on the evidence”, while the second states somewhat defensively that “okay perhaps that doesn’t go down particularly well these days” and “it perhaps is wrong”. This suggests that prioritising patient experiences over clinical evidence is somewhat subversive and counter-cultural, a concern echoed by Sir Denis Pereira Gray (Pereira Gray, 2005). The role of patient experience in influencing clinicians’ views will be developed further in section 5.4.1.

Past clinical experiences were also reported by doctors as highly influential in their decision-making.

One [influence on decision-making] is my own past experience, so I tried this before and it worked and I tried this before and it was a disaster. So I may not try it again or try it with more caution. (Doctor, PS, line 89)

Another confessed that sometimes her previous experiences disagreed with the evidence.

Well obviously I take into account the evidence, but I don’t tend to look at the whole evidence right across the board and going back a long way. Like the recent HRT, everybody sort of reacts and well we’ve got this one study and I’m sorry I can’t just throw away all the things I’ve read about and your own experience. (Doctor, WW, line 111)

So, personal interpretation of the evidence is often coloured by tacit knowledge gained from patient feedback or prior clinical experiences. This contributes to the decision about which studies are accepted or rejected. This adds further complications to the House of Lord’s recommendation that complementary therapies with “strong” evidence be mainstreamed.

4.6.2 Experts

Patients and prior clinical experiences are powerful sources that shape views, but another is specialists or experts in the subject matter. For example, an executive

manager at the first site said during interview that he learnt of evidence mainly through what was presented at PEC meetings. In these meetings, the lead PCT manager for an area, such as elderly services, gives a brief overview of the evidence from clinical trials and service evaluations, as part of their introduction to their presentation on current service provision. Another manager identified subject specialists outside his organisation as sources of expert advice.

*I remember speaking some time ago to someone from the Homeopathic Hospital in London and clearly there is [evidence]. I think, it struck me that there was research which shows that some things are effective and some things aren't and it needs to be targeted on the people for whom it works and not just on everyone. So, I think we do know there are some interventions that do work.
(PCT manager, BC, line 25)*

But the circle of experts can extend wider; as a result of this study, I too was allowed into those ranks. During my interview with a senior executive of the PCT, I mentioned several recently published trials that provided convincing evidence about complementary therapies, specifically the UK BEAM trial on osteopathy and chiropractic (UK BEAM Trial Team, 2004b; UK BEAM Trial Team, 2004a), the acupuncture headache trial (Vickers *et al.* 2004; Wonderling *et al.* 2004) and the St. John's Wort and paroxetine trial (Szegedi *et al.* 2004). Two weeks later I observed a PEC meeting on complementary therapies, which the Chief Executive opened by saying that he thought there was now quite a lot of evidence for some complementary therapies. Perhaps he came to this conclusion through some other route, but the timing between our meeting and his subsequent statement left me wondering about my influence on his views. This suspicion was reinforced, as he mentioned to a mutual contact that our interview had "made me think".

Two literature reviews on commissioners' decision-making processes offer some confirmation that this experience is unlikely to be an isolated incident. Both concluded that personal contact with a researcher is the most highly influential facilitator in helping policy makers to use evidence to shape policy making (Innvaer *et al.* 2002; Lavis *et al.* 2005).

4.6.3 Trusted colleagues

Trusted colleagues also influence the views and behaviour of NHS professionals.

Seeing how my colleagues manage things [influences decision-making]. You look back through someone's record and you think - oh that's interesting they came with this before and Dr. So and So did that and it seemed to work. Or I noticed that somebody else had this in the past and this is what happened to them. Maybe even a specialist colleague, letters from colleagues. So you learn from that. (Doctor, PS, line 89)

Q: Let's say that a patient comes along and you think - oh, I'm not too sure what to do here - what do you do?

A: Just explaining to the patient that in your situation I can't decide what to do and I'm going to discuss with my colleague, my senior colleague, that has more experience... if I feel that I'm not sure what to do with this patient or whether I will start her on [drug treatment] or whether I will refer her for homeopathy, I'm indecisive. So, every Monday I see [Head of the service] so I am discussing with her. Family planning, I'm discussing with my senior lead clinician [name]. (Doctor SH, line 131)

Serendipitously, I observed this firsthand in my office at the University of Bristol with two academic GPs (pseudonyms George and Beth). In discussing B12 injections to boost immunity, George said he would not prescribe them because of lack of information on effectiveness and safety. Beth agreed, saying she had not encountered this situation herself but she too would not administer them, although she admitted she was not familiar with the evidence either. At that point, they moved on to another topic.

I then challenged George to look up the evidence himself. He said he did not have the time to either locate the appropriate studies or critically appraise any he found. Moreover, he thought it unlikely that his usual trusted sources would include information on B12 injections for immunity. But he accepted my challenge.

He then spent twenty minutes futilely searching Clinical Evidence, GP Notebook and the Department of Health website. He did not turn to Medline because he thought Medline evidence was too "arcane". He also said it was "rare" for him to directly search for evidence, except in unusual circumstances, such as a new drug for multiple sclerosis.

This interaction is an excellent example of how clinicians reflect on their behaviour with colleagues and then co-construct understandings of acceptable clinical practice as identified in other studies (Fitzgerald *et al.* 2003; Gabbay and le May, 2004) (see section

4.6 for more details). In this instance, an assumption was made by both - that the clinical evidence did not exist. Nonetheless, they agreed that B12 injections were not advisable, although they had no factual basis for this judgment. Their views were derived from mutually agreed perceptions, rather than actual knowledge. This then confirmed George's current clinical practice not to prescribe B12 injections and possibly influenced Beth's future practice, if any of her patients made a similar request. Direct consideration of the evidence played no part in their decision-making process. Several other interesting points can be drawn from this incident. First George, like other NHS professionals in this study, operated within his own particular framework of a hierarchy of evidence sources, with Clinical Evidence, GP notebook and the Department of Health website at the top of his list. Second, he acknowledged that shortage of time and the unlikelihood of finding an answer, coupled with the low priority of vitamin B12 injections in his clinical practice, meant he was less inclined to search for evidence. Third, he was right; his usual mainstream sources did not have the information needed, as is often the case for alternative interventions. This thereby justified his opinion that searching the evidence was pointless and possibly further confirmed his view that Vitamin B12 injections were not 'important' because, by inference, if they were, then his sources would have some information. Fourth, unlike most of my study participants who hinted (but often shied away from directly confirming) that they did not access the evidence themselves, George admitted that it was unusual for him to actually search for evidence. Finally, if even academic GPs, who specialise in generating research questions and searching the literature, do not access the evidence on alternative interventions, then how likely are non-academic clinicians to do so?

4.7 Summary

4.7.1 Main findings

This chapter has covered a great deal of ground. To summarise, the key points are:

- In exploring the theme of 'paradigmatic tensions', there are differences between biomedical professionals and complementary therapists in understandings of the existence and impact of "non-material" influences (e.g. chi, vital force) and

different standards of identifying valid health interventions with the more scientifically minded asking “does it work?” and others enquiring “does it have a benefit?”

- In considering the theme of ‘reality of evidence available’, evidence from service evaluations suggests that NHS complementary therapy services can make a moderately strong impact on self-reported health outcomes, but the data on cost pressures are more tenuous. This information is needed to determine if services are “add on” or “instead of”.
- Under this same theme, I argue that clinical evidence on acupuncture and homeopathy suggests that acupuncture is effective for a limited number of conditions while the evidence for homeopathy is mired in the debate about plausible mechanisms of action. Both evidence bases suffer from insufficient numbers of good quality trials.
- In exploring the theme of ‘rhetoric on evidence based decision making’, the discourse at national and local level suggests there is consensus that the production of “strong” evidence of therapeutic effectiveness via clinical trials is a pre-cursor to mainstreaming into the NHS.
- Findings within the theme of ‘discrepancies between rhetoric and reality’ indicate that despite this rhetoric, NHS professionals appear to rely more on what they believe to be true than what they know to be true.
 - Few appeared to have directly access the evidence, partly because of a lack of knowledge of where to find credible sources
 - Publication bias means that usual mainstream sources tend to report negative studies, if any can be found at all
 - Interpretation bias, which we all suffer from, means that even if a positive study is located, personal filters may lead to discrediting the findings
- In exploring the theme of ‘other influences on decision making’, I found several potentially powerful factors such as patient experiences, expert views, personal contact with researchers and opinions of trusted colleagues. These appear to help co-construct NHS professionals’ beliefs.

4.7.2 Comparison of themes with existing literature

In comparing the themes of this study with those identified in existing literature, the themes of paradigmatic tensions between medical and complementary therapy models of health, the rhetoric around evidence based decision making and the reality of evidence available have been identified in other studies. However, a previously little explored theme is the documenting of a range of discrepancies between rhetoric and reality with regards to NHS professionals' attitudes and behaviour towards complementary therapies. As a result, this study challenges previous research that takes protestations of 'clinical evidence as ultimate arbitrator of mainstreaming' at face value. Furthermore, although a few other studies have identified the theme of 'other influences on decision making', this study adds to the growing literature in this field. For example, in their study of how "credible" evidence influenced NHS professionals, Fitzgerald and colleagues found

Doctors stated that the people whom they go to for information and verification are those whom they know personally, i.e. consultants at local hospitals, their immediate colleagues or other doctors whom they had known for a long time (Fitzgerald et al. 2003).

They also found that there was "no clearcut, agreed definition" of credible evidence amongst clinicians and PCT managers for the four biomedical interventions under study (Fitzgerald *et al.* 2003).

Gabbay and le May carried out an ethnographic study observing and interviewing 13 clinicians in two sites over two years. Their aim was to explore in depth how GPs and nurses make healthcare decisions. They found that

Clinicians rarely accessed and used explicit evidence from research or other sources directly, but relied on "mindlines" – collectively reinforced, internalised, tacit guidelines. These were informed by brief reading but mainly by their own and their colleagues' experience, their interactions with each other and with opinion leaders, patients and pharmaceutical representatives and other sources of largely tacit knowledge. Mediated by organisational demands and constraints, mindlines were iteratively negotiated with a variety of key actors, often through a range of informal interaction in fluid "communities of practice", resulting in socially constructed "knowledge in practice" (Gabbay and le May, 2004).

They conclude that informal networking is a useful approach to convey evidence to clinicians.

Interestingly, in conversation with the Head of Research for the British Association of Counselling Practitioners (BACP), I asked about the role of informal networking in mainstreaming counselling. She said that pressure was applied at local level, not least because many doctors were married to counsellors. She also said that BACP recognised the importance of grassroots opinion and so actively devised strategies to create a groundswell of acceptance amongst local clinicians. Perhaps I am being overly pessimistic, but I see little evidence of such sophisticated tactics among complementary therapists.

Moreover, the literature suggests that the propensity for personal views to filter acceptance of clinical evidence applies to healthcare in general, not just complementary therapies. Raine and colleagues carried out a study with clinicians on the level of agreement with guidelines for several interventions and conditions such as antidepressants for irritable bowel syndrome and chronic back pain. They found that:

Concordance was more likely if a literature review was provided and if this evidence supported clinicians' experiences and beliefs. If clinical experience and beliefs were not consistent with research evidence, then the experience and beliefs seemed to take precedence (Raine et al. 2005).

In an interesting focus group study of 19 doctors, Freeman and Sweeney also found that beliefs and prior clinical experience with “mishaps or spectacular clinical successes” were powerful, direct influences on subsequent practice (Freeman and Sweeney, 2001).

As the findings of these studies are comparable with my own, this suggests that the decision-making processes that clinicians undertake when considering complementary therapies are not vastly dissimilar from that taken for biomedical interventions. However, complementary therapies might face especially high hurdles. For example, although clinical evidence for biomedical interventions might be hard to dismiss, a study found that once clinicians are entrenched in their view that complementary therapies are ineffective, the production of good evidence is unlikely to persuade them otherwise.

Interviewer: What if we could show you good evidence on the effectiveness of a complementary therapy?

Medical Oncologist: Well, I suppose we'd use it, but . . . for most complementary things there is never going to be the evidence. If

they actually worked, I think we would probably already know about it . . . occasionally things slip through like acupuncture but this is an exception. (Female, Research and Clinical, 43 years) (Broom and Tovey, 2007) (Emphasis mine)

I have highlighted the last phrase of this quote, because it suggests that the call for clinical evidence may be to ensure that complementary therapies do not “slip through”. This possible role of clinical evidence in rationing the access of complementary therapies to the NHS will be further developed in the discussion chapter.

4.8 Conclusion

Revisiting the main question within this thesis about the mainstreaming of complementary therapies, at the macro level of evidence, I found that the complementary therapy community would have to alter ‘perceptions’ widespread amongst NHS professionals that complementary therapies do not have a clinical evidence base and thus, do not work. Possibly, this may not be brought about through the production of further randomised controlled trials, but rather through identifying and capitalising on other powerful influences on decision-making. This is discussed thoroughly in Chapter 7. Having explored the macro topic of evidence, the next chapter focuses on the meso level of service design and delivery.

CHAPTER 5 Service design and delivery

5.1 Introduction

This chapter focuses on the meso level of organisations in exploring the mainstreaming of complementary therapies into the NHS. In particular, it considers service design and delivery, with the assumption that certain service models might appeal more to mainstream gatekeepers than others. Accordingly, the key question of this chapter is: What does a ‘NHS acceptable’ complementary therapy service look like? By ‘NHS acceptable’, I mean a service that has the endorsement of a range of key NHS professionals, specifically commissioning managers and clinicians. For clinicians, that endorsement might take the form of referrals, while for commissioners, it could be a willingness to allocate NHS funding.

In constructing this chapter, I have drawn on the following sources of data:

- Documentation, including complementary therapy service annual reports and evaluations from the two case sites, funding bids, minutes of meetings, published papers and referral databases
- Interviews with all study participants
- Wider reading, including literature on complementary therapy service provision, reasons for complementary therapy use and “effectiveness gaps”

From these data sources, several themes were identified and developed in relation to service design and delivery in mainstreaming complementary therapies. These themes are detailed in the table below. For detailed description of how these themes were developed, see 3.5.1, 3.5.2 and Appendix K.

Table 6 Key themes, data sources and process of derivation of theme for the meso level topic of service design and delivery

Theme	Data sources contributing to theme development	Process of derivation of theme
Description and history of development of services at case sites	Interviews with study participants Documentation - referral databases, funding bids, annual reports, meeting minutes and published audits	Thematic analysis of study interviews Analysis of documentation
Structural factors influencing service design, delivery and survival	Interviews with study participants Literature on reasons for complementary therapy use, effectiveness gaps and the sociology of complementary therapies Documentation - funding bids, annual reports and evaluations	Thematic analysis of study interviews Analysis of documentation
Factors that did not influence service design, delivery or survival	Interviews with study participants Documentation – referral databases, emails	Thematic analysis of study interviews Analysis of documentation
Process factors influencing service design, delivery and survival	Interviews with study participants Documentation – referral databases, emails	Thematic analysis of study interviews Analysis of documentation

I will begin this chapter by describing actual service models, specifically those operating in the two case sites included in my fieldwork. In doing so, I describe the history of development of services at case site'. This chapter continues, by constructing and elaborating on the structural features of an ideal 'NHS acceptable' complementary therapy service in developing the theme of 'structural factors influencing service design, delivery and survival'. Next I explore process factors that I thought would have an impact on NHS professionals' attitudes and behaviour towards complementary therapy services, but found they did not. The final section develops the theme of 'process factors that did influence service design, delivery and survival'.

As ever with qualitative research, there is a balance between providing enough detail to give readers adequate context, without unmasking the case site and study participants and breaking confidentiality (Johnson and Macleod Clark, 2003). To maintain anonymity, I have changed the names of the organisations and people involved and have not directly cited reports or evaluations of specific services. I have also camouflaged other characteristics, such as the conditions treated at the second case site, as providing this information would unmask the site in a community as small as that of complementary therapies.

5.2 Description and history of development of services at case sites

5.2.1 Description of case site one

In some ways the first service studied was very fortunate, as it was located in a city in southern England, where complementary therapy provision was thriving. Dozens of private complementary therapy clinics were situated here. Activity and interest in the field of complementary therapies came from several quarters throughout the city: general practices, a local hospital which had a specialist unit in homeopathy, a complementary therapy lobbying group, universities and several local charities providing complementary therapies. In addition, running concurrently in the city during the study period (2003-2007) were two other complementary therapy services located on NHS premises with professional practitioners.

However, the local public health economy was not quite so buoyant, as during fieldwork, the Primary Care Trust (PCT) carried debts estimated as over £4 million. Furthermore, the neighbourhood in which the service was located was an isolated area cut off by railways, arterial roads and industrial areas. Over 3,000 households were located in the area and there was a high incidence of drug and alcohol abuse, unemployment and teenage pregnancy. The area also attracted large populations of refugees, most recently Somalians.

The complementary therapy service was funded by non-NHS monies and grew from local community development initiatives, therefore it was not a 'NHS service' as such, but the treatments were delivered in two NHS GP surgeries. The original premises for one surgery were portacabins. The consultation rooms and the offices used by service administrators suffered from damp and smelt of mould. In 2004 and 2005, both GP surgeries moved into two separate, light, airy buildings, as did the complementary therapy service.

At the new premises of one GP surgery, from early 2005, the complementary therapy service had access to a treatment room off the main waiting room, which was also used by other visiting professionals such as chiropodists. At the other GP surgery, from summer 2004, the complementary therapy service had its own office on the first floor with several desks. The treatment room, for its exclusive use, was just across the corridor. It was a pleasant room with plenty of natural light, a plant, a bookshelf with several books, a couch, a sink, several chairs and two bins. The new site for this surgery also housed a district nurse and health visiting services, a GP practice with four GP principals, a pharmacy and several community projects such as a wellbeing initiative for new mothers.

From the launch of the complementary therapy service in the summer 2001 until fieldwork ended in 2006, five administrative staff were employed in total, with usually one or two running the service at any particular time. They managed over 15 non-medical therapists, offering around ten different therapies, on a one to one treatment basis. Therapies included acupuncture, massage, chiropractic, nutrition, osteopathy, reflexology and shiatsu, amongst others. Therapists were paid £21 per treatment, regardless of the length of the consultation, which varied from 30 to 60 minutes.

Concessionary patients contributed £3 towards costs, while waged clients paid £5. With a funding crisis in 2005, patient contributions increased to £5, £10 or £15.

5.2.1.1 Referrals

Clients referred to the service could receive a maximum of eight treatments. If clients required more, a further set of eight were requested, which was usually granted. In addition to individual treatments, the project also ran group and taster sessions for older people, young people, children and babies – the latter usually for massage. There were two main referral routes into the service: NHS professionals from the two GP surgeries could refer and the service also accepted self-referrals from patients registered at either of the two GP practices.

Table 7 Proportions of referrals into the service at site one by type

Source of referral	June 01 -Dec 2002#	Annual report 2003-04#	Annual report 2004 – 05#
GPs	36%	59%	70%
Self	42%	31%	16%*
Healthworkers e.g. nurses	13%	3%	3%
Local drug & alcohol project	7%	7%	11%
Total number of individuals receiving treatment	171	394	245

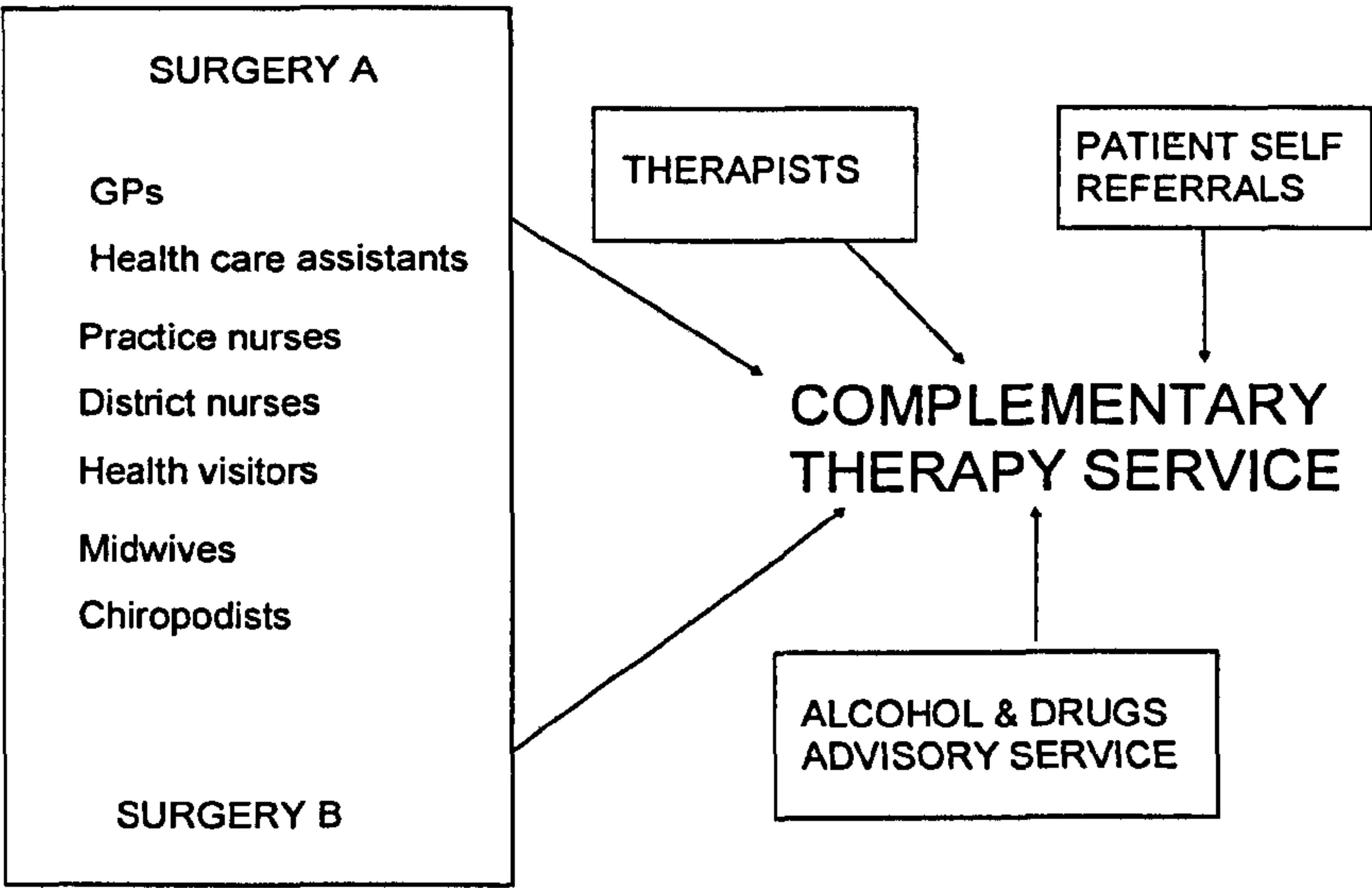
#Numbers taken directly from reports, hence any inconsistencies due to reporting.

*In Spring 2005, self-referrals stopped because of funding difficulties.

The table above indicates that initially self-referrals formed the greatest proportion of referrals, but as the service developed, GPs gradually became the highest referrers. However the potential number of professional health care referrers was larger than just

GPs, as any district nurse or health visitor, practice nurse or other health worker based at the two GP surgeries, could also refer (see Figure 4 below). There were no specific referral criteria, although there was a referral form.

Figure 4 Referral pathways to complementary therapy service site 1



The 2004-2005 report detailing referral data for over four years, identified the main presenting complaints as musculoskeletal (n=756), psychological (n=249) and other (n=112). The therapies most commonly referred to, in order of frequency, were: osteopathy, chiropractic, massage and acupuncture. About 80% of the clients were white and 20% were from black or minority ethnic groups; two thirds were women and the majority aged between 26 and 60 years.

Table 8 Total number of referrals to case site one from June 2001 – Nov 2006

	GP	Self	Drug & alcohol service	Nurses & other health professionals
*Total number of referrals 1250 analysable	59%	26%	8%	7%
Total number of referrers 54	24	NA	13	17

*69 referrals did not include information on who referred and so were not included.

The results presented in this table lead to several conclusions, namely:

- The service had a large number of referrers (n=54).
- There were four GP principals at the main surgery that hosted the complementary therapy service and eight at the neighbouring practice. As 24 different GPs referred in total, locum GPs and new staff may account for the difference.
- A smaller proportion of referrals came from nurses, drug and alcohol service workers and other health professionals, which is perhaps unsurprising, as they were less targeted in activities promoting the complementary therapy service.

Table 9 Comparison of referral data by GPs from host surgery (A) and neighbouring surgery (B)

	Surgery A	Surgery B	Other*
Total number of GP principals	4	8	-
Total number of GPs referring to service (n=24)	7	15	2
Proportion of referrals	68%	32%	-
Number of doctors as top four referrers	4	0	-
Proportion of referrals from doctor with highest referral rate	28%	9%	
Number of doctors accountable for 1% of referrals or less	2	8	2
Number of GPs who referred to 5 or more different therapies	3	9	0

*One GP worked in both surgery A & B and another worked in neither but still made a referral.

The results presented in the table leads to several further conclusions, namely:

- Where a service is situated appears to make a difference. Even though there were fewer doctors at the host surgery than the neighbouring surgery, doctors from the host surgery referred more patients. Doctors at the host surgery had a referral average of nearly 10%, while doctors at the other surgery averaged 2%. The four highest referring doctors all came from the host surgery. The highest referring doctor in the host surgery made three times as many referrals as the highest referring doctor from the neighbouring surgery.
- About half of the referring doctors at both surgeries referred to five or more therapies. This suggests that doctors may be open to therapies other than manipulation therapies, despite their rhetoric to the contrary.

5.2.1.2 History of development

This complementary therapy service grew out of a wider inner city regeneration initiative. A partnership between local residents, the city council, the health authority,

local agencies and the police was formed and resulted in an organisation (pseudonym TAT). TAT's aim was to put forward a bid for the New Deal for Communities funding in 1998. This funding was made available nationally to some of the most deprived neighbourhoods in the country by the Office of the Deputy Prime Minister. In early 2000, TAT was successful and won £50 million, which was subsequently allocated to numerous community development projects in the area.

MD, a local resident and reiki practitioner, was employed by TAT as an assistant community development worker. With a strong interest in complementary therapies, he formed a group of local resident therapists to develop a complementary therapy service. Their aim was to provide low cost therapies for the local community. The service also intended to employ local therapists, so there was a personal, as well as a community, incentive.

The service development group convened in the summer of 2000 and thereafter, met weekly for over a year. About a dozen different people attended on occasion, with a core group of about five or six. They discussed: job descriptions, cost of treatments, therapies to include, insurance, equipment, taster days, referral guidelines, publicity, ways to evaluate and funding. Minutes also document the wide range of key people the development group needed to involve and persuade from organisations such as TAT, three GP surgeries (initially a third surgery was also approached), the health authority and subsequently the Primary Care Group, other NHS complementary therapy services, the Foundation for Integrated Medicine (subsequently the Foundation for Integrated Health) and academia. They navigated a bewildering array of committees, formed for various purposes by TAT, social services and health agencies, as they went through the formal application processes. Everyone in the development group, except for MD, carried out this work without pay, in their own time.

Working towards agreement, both within the service development group and across the different committees, was challenging. For example, within the service development group, members recalled tensions around patient contributions and differing personal agendas.

A lot of the meetings were taken up by how much we would charge. And some said, "Well, if people earn then they should pay." And you know we just started arguing again and debating about well hang on a minute you know, there's somebody may work but how

can you tell, on the sliding scale thing? ...But there were lots of debates about this amount of money, that amount of money. (Service co-ordinator, MD, line 293)

They [the meetings] could be quite fiery at times, so a couple of people with totally opposite views. And I think we were very split because one side was like myself and several others that wanted to provide a service in the community at subsidised rates for a few hours of our time and were willing to make a bit of a business out of it. And there were a few people that wanted to make that their main income and so yeah, there was, I always felt there was that divide. (Therapist, MM, line 72)

The complementary therapy service development group needed approval from the health professionals' group, which had the remit of developing the new surgery premises. Representatives came from social services, the health authority and local clinicians. The health professionals' group had its own tensions.

When I started going to it [health professionals' group], it was a bit of a dysfunctional group, to be quite honest with you. It didn't seem to have much of a sense of purpose. I tried to steer it in a direction to get more ideas about developing services once the [new surgery] was up and running. But to be honest, it's been a hard group to pull together and get going. (PCT manager, BC, line 13)

Interestingly, study participants agreed that although funded by TAT, TAT committees had little influence over service development. The primary influence came from the health professionals' group. In particular, clinicians from the two surgeries and local commissioners were instrumental in selecting the therapies.

Shiatsu in the beginning, they couldn't get their head around shiatsu. But yes, it was basically shiatsu and reiki that they didn't want. They just wanted the ones that they knew. (Service co-ordinator, MD, line 241)

I think we had an influence in the type of therapist we thought would be useful to have in the project. I can remember discussions about crystal therapy and reiki and stuff and decided that there wasn't much evidence of benefit for those particular ones and to go for things like osteopathy, aromatherapy, massage and stuff. (Doctor, HC, line 14)

The service development group needed to get the GPs on board because they wanted to use surgery premises and hoped to encourage GP referrals.

We'd have been using their premises and surgeries...so it was basically saying well --- use these therapies, we need your permission to have it [here]. But it felt like we needed the doctors to

accept that they were there. Because part of it was, there'd be referrals from the doctors. And we needed to know the doctors were OK with that. So there was a bit of compromising, well quite a bit of compromising to do with the surgeries. (Service co-ordinator, MD, line 233)

But the service development group was not without influence. The health professionals made their selections from a shortlist, devised (mainly) on the basis of the therapies practised by members of the service development group.

5.2.1.3 Funding

Eventually, the service development group was successful and, in the summer of 2001, treatments started for an eight month period with a service cost of £39,202, awarded by TAT. In spring 2002, the service re-applied and received an eight month extension with further funding of £48,389. In autumn 2002, they bid again and won funding for a three year period of £231,146. In total, TAT funding amounted to £318,737.

In early 2005, the service had about six months of TAT funding left as numerous bids had failed. A “crisis” meeting was called and there was a high turnout including: GPs, TAT staff, academics, clients, therapists, past co-ordinators and PCT managers. The outcome of that meeting was a revived steering group, which mounted a pressure campaign to ‘save the service’, with tactics including: articles in the local press, letters from patients to the PCT, letters to MPs and the PCT Chief Executive and an application for a national award (which they won). In addition, they increased fees, discontinued self-referrals, cut back the numbers of sessions of therapies and established a private service for local businesses. In the summer of 2005, they were given a reprieve with a bridging loan from TAT until autumn 2006.

Just as this funding finished, a significantly pared down service won PCT funding for a year from 2006-2007, through the newly implemented practice based commissioning initiative. In part, this came about because a GP from one of the surgeries who championed the service, now also had a role within the PCT and could access key people such as the Director of Finance. Mixing complementary and mainstream treatments, the new service offered osteopathy, chiropractic and physiotherapy for musculoskeletal conditions for a maximum of two and a half sessions per patient.

5.2.2 Description of case site two

The second complementary therapy service was located in a city in northern England. Interest in complementary therapies came from local universities and a charity providing complementary therapies, but private provision was not as widespread as in case site one. Again the PCT carried a deficit - this time of over £3 million.

The service was housed in a community clinic located in a functional five storey building in the city centre. A range of clinics, for drug and alcohol dependency, sexual health, teenage mothers, children and asylum seekers, were offered. After entering the building from an alleyway, visitors came into a maze of corridors, lit by neon strips, with security doors requiring key codes for access. A two person lift was situated at one side of the building; at the other side were narrow stairs used by patients. Space was at a premium as chairs, trolleys and machines littered the corridors.

Treatments took place in consulting rooms allocated to different professionals throughout the week. The room for the homeopath I observed was on the ground floor. Crowded with a desk, several chairs, a sink, a broken weighing machine and a cabinet, it had little natural light from a small barred window. The room was cold.

This complementary therapy service was part of a women's health clinic, specialising in female hormonal conditions. At the beginning of fieldwork (January 2006), a nurse offering aromatherapy and reflexology was retiring, so those therapies were being discontinued by April 5 2006. The homeopathy service was provided by a professional homeopath and a doctor, who was a former GP.

Patients were allocated six consultations. For homeopathy, the sessions were booked monthly or six weekly, at the convenience of the patient and therapist. For aromatherapy and reflexology, patients were booked into a block of weekly appointments over six weeks. Occasionally patients of either therapy would require an extension of six sessions, which was usually granted.

The nurse offering reflexology and aromatherapy worked one session a week for six weeks and then took several weeks off, before starting a new six week block. The two homeopaths each did three sessions a month, on Tuesday afternoons or Wednesday mornings. A session ran for four hours. Therapists were paid £160 for each session, regardless of the number of consultations or their professional status. For homeopathy, the first treatment lasted an hour and subsequent consultations were 20-30 minutes. In

an average session, each homeopath saw six to eight patients. Aromatherapy and reflexology treatments given by the nurse would last an hour, but she would treat two patients simultaneously in different rooms. She would give a treatment to a client for half an hour, then play music and let the client relax for another half hour while she began treatment with the next patient booked. Because there was not enough space for the nurse to occupy two rooms simultaneously at the city centre clinic, in the last eighteen months of this service, she moved to a GP surgery on the outskirts of the city. I could not obtain a precise costing of the service, but annual gross salary costs for the homeopaths would be close to £18,000. The costs of the aromatherapy/ reflexology service were absorbed into overall costs for the women's health clinic such as heating, light and administrative support. The original bid estimated the cost of the service to be £1,025 per month, but undoubtedly it was higher eight years on.

5.2.2.1 Referrals

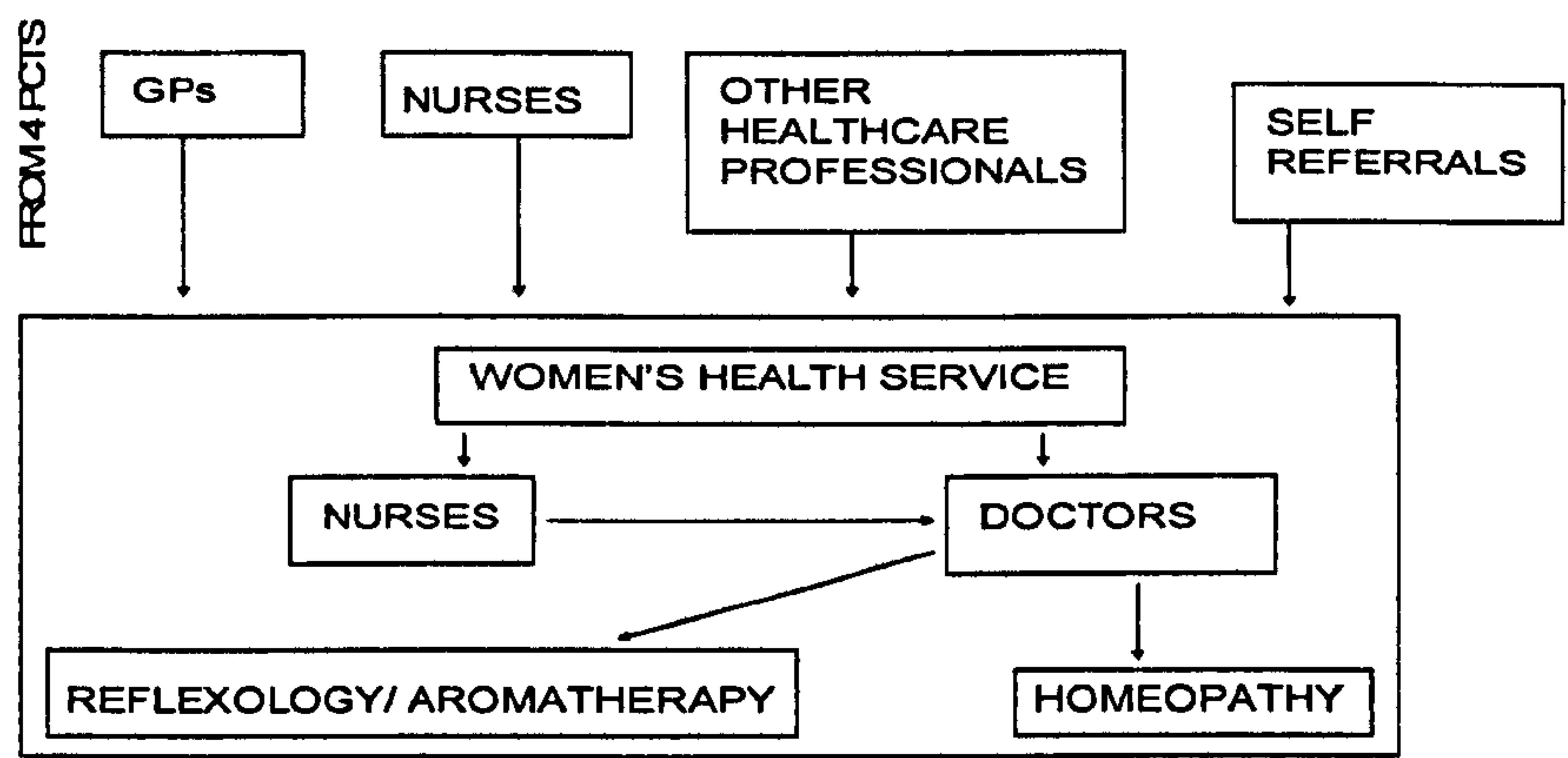
The women's health clinic, and consequently the complementary therapy service, was entirely funded by one PCT, but they received referrals from all four PCTs across the city. NHS professional and patient self-referrals were accepted into the women's health service, but the current head of the service estimated that self-referrals were more common at about 70%.

Women referred into the women's health service were invited to attend a group education session run by two nurses. In these sessions, nurses gave information on lifestyle changes (diet and exercise), medications, herbal products, homeopathy and aromatherapy/ reflexology. At this point, some women would decide to manage their condition themselves, but those who wanted complementary therapies or pharmacological treatments would then see a specialist doctor from the women's health clinic.

Each of the three specialist doctors ran one three hour session a week. During the initial appointments of thirty minutes, the doctors would discuss the different options with the women and the women would choose which treatment they favoured. Women who did not want or could not have pharmacological interventions tended to be referred to the complementary therapy service, either homeopathy or aromatherapy/

reflexology – not both. For those women who chose biomedical treatment, follow up appointments were scheduled every three months and lasted for 15 minutes.

Figure 5 Referral pathways to complementary therapy service site 2



Although referral rates varied, one doctor estimated that she referred about one patient every session to the homeopathy service and one patient every two sessions to the aromatherapy/ reflexology service. A MYMOP audit of the service found that 124 women were referred to the homeopathy service alone from 1 January 2001 to 31 December 2003. Conclusions drawn from raw data recorded in the referral book were:

- Over the 23 months for which data are available, 178 referrals were to the homeopathy and aromatherapy/ reflexology services making an average of 7.7 a month.
- Only three doctors and a nurse therapist (who made one cross referral) referred, giving this service a very small referral base.
- The doctor with the highest number of referrals from August 2005 to January 2006 had no personal experience of complementary therapies and during interviews, showed the most confusion about complementary therapies.

Once referred to the complementary therapy service, the patient was put on a waiting list. Average waiting time was two to three months. Women were allocated on a first come, first served basis; doctors did not specify which homeopath individual patients were to see.

Doctors did, however, make distinctions between the appropriateness of the different therapies. In general, the doctors perceived aromatherapy and reflexology as useful for stress reduction while homeopathy was for symptom relief.

The aromatherapy and reflexology tend to be more [for] the [younger] ladies...and sometimes early [middle-aged] ladies. And we'll see quite a few of these coming through our clinic and you will tend to get somebody that you can see they just need a little bit of time for themselves and it's really more gearing that towards that, just a bit of time out, a bit of one time for themselves, a bit of relaxation. So I would be really directing the ladies that I can see that need relaxation rather than true therapy, I would say, to the aromatherapist. (Doctor, TL, line 45)

For me, the homeopathy for many women is getting rid of the [symptoms], because nothing else can do ... If they can't have [drug treatment], there's very little else that can modify those, and that's the one thing that, for me, the homeopathy can do. (Doctor, SP, line 130)

5.2.2.2 History of development

Unlike the service at the first site, which grew from within a geographically contained area, the second service came about as disparate activities across the city converged. In 1997, a group of health professionals were convened by a retired GP to look at ways of incorporating complementary therapies into the NHS. Recollections of membership are hazy, but one influential member was a doctor with an interest in women's health (WW).

Meanwhile, on the other side of the city, another doctor, a senior GP trained in homeopathy (TT), organised group meetings for anyone interested in homeopathy. At one of these, TT met RR who was a professional homeopath. In 1998, TT and RR opened a private homeopathy clinic together. TT also knew WW. At this point, circles converged.

I rang round some of my friends, you know, to tell them what we were doing and I rang WW who was at the [women's health] clinic. We'd sat together on various things, something to do with drug trials in [the city] or something and I rang her and I said, "Oh, just to tell you I'm working as a homeopath in [the city] now, even though I've left general practice". "Oh", she said, "you couldn't have rung at a better time." And I said, "Why?" And she said, "Well", she said, "we sent out these questionnaires to the people coming to the [women's health] clinic to say what else would they

like, apart from [drug treatments], and they've opted for aromatherapy, herbalism, reflexology and homeopathy, and would you like to come and talk to us about it?" And that's how it happened. So I went. (Homeopath, TT, line 57)

From those networks, a service development group was convened which included WW, two homeopaths (TT and RR), an aromatherapist who was already working within the NHS (BA) and an academic. For six months, they steadily developed the service, which aimed to broaden the service options for women for whom pharmacological treatments were not always appropriate or effective. They put in a bid to the local community health trust, a provider organisation, where WW was already employed. The proposed service featured those therapies provided by members of the service development group.

I think when it came down we decided in this general group that it would be two things and it's not very scientific but it was because BA was there we decided on the aromatherapy and because TT was involved in this sort of development group and she got the interest, we got the people on tap if you like. They were able to deliver it. We didn't have to go and look for somebody else to come in. And they were prepared to give it a go and there was a certain amount of voluntary input if you like, even if it's only the enthusiasm. (Doctor, WW, line 72)

Meanwhile, as the group worked on the service design, behind the scenes WW was influencing the right people both within her own organisation and the health authority.

Q: How high did you have to go to try to get them on board?

A: Yes, well it would have been... fairly near the top, obviously not the Chief Executive, but at a fairly high level below that.

Q: So it would have been Board members then?

A: Yes, there were one or two Board members.

Q: And did you have to talk to people in Public Health?

A: Public Health particularly and health promotion. And they got health promotion people then. Yes, they were the main people. (Doctor, WW, line 37)

In early 1998, funding was granted for three years by the community trust, as part of their service improvement and development programme.

By 2001, when that initial money ran out, WW was in a greater position of power, with financial control of all women's health services within a community trust. By

rationalising family planning services, she freed up money for the complementary therapy service, so they continued to be funded by the NHS. Funding was extended until March 2002, when the medical homeopath got a call from the Primary Care Trust.

They rang me up and said, "We're closing, closing the clinic down." And I rang back and I said, "Right, you inform all the ladies that they're not going to have this clinic any more. I'm not doing it." Now, whether that frightened her or what, I don't know. But she rang me three days later and said, "We're reinstating it". (Homeopath, TT, line 96)

By December 2002, WW was "forced" into retirement and left both the women's health service and the PCT. Although there were some fears that without WW the complementary therapy service would be cut, initially it became more secure, as the new head of the service arranged for service level agreements (NHS contracts) for the homeopaths.

But in the summer of 2006, everything changed. Although clinicians and homeopaths within the women's health clinic were conscious of local and national NHS financial crises, they were taken unawares when the homeopathy service was discontinued. In interviews just four months before, the consensus was that the homeopathy service was relatively secure. But it was terminated, in a wave of cuts affecting many NHS complementary therapy services across the country.

5.2.3 Inter-professional relationships and service champions

In reviewing the history and development of these two services, two key points emerge. The first is that therapies were primarily selected as a result of personal contacts, not on the basis of "robust" clinical evidence. At the first case site, the service development committee mainly proposed therapies that were practised by group members, while at the second previous personal relationships between doctors and therapists determined which therapies were provided. Perhaps more recently, personal contacts may be less influential, as therapies selected in 2006 for the revamped service at the first case site (osteopathy, chiropractic and physiotherapy) were not chosen because practitioners of these disciplines were already known; instead, they were selected because these therapies are popular with GPs and there is a widespread perception of a better evidence base (see 5.3.1.). But findings from fieldwork at the two case sites suggest that

at the time of inception, therapy selection was based more on “who you know” than the intrinsic value or perceived benefits of the therapy.

The second point is that service inception and survival at these two case sites appeared to depend on a few committed, well placed individuals with leadership qualities. At the first site, as a therapist, MD had credibility with local therapists; he also had contacts with potential funders within TAT in his role as community development worker. Both were essential in setting up the service. Subsequent co-ordinators, of which there were many, generally did not have the same drive or connections, but when initial funding stopped fortunately another well placed individual was now championing the service – a GP who also had a managerial function at the local PCT. Although occasionally subject to doubts, he promoted the service amongst contacts within the PCT and elsewhere.

A: I think my role has changed from being pretty much exclusively in the research side, evaluation side of [the service], to a more [service] advocate....

Q: An advocate with whom?

A: Anybody that I can find. (laughs) Anyone that stands still. (laughs) (Doctor, BP, line 20)

So, the complementary therapy service at the first site had a clinical champion campaigning at the local PCT when widespread service cuts engulfed the NHS in mid-2006. Unfortunately, at the second site the homeopathy service, and the women’s health clinic as a whole, had lost their champion several years earlier. Several study participants noted that when WW was in charge, the women’s health service was continually promoted.

I don’t think this place is known about in the same way as it was in WW’s day, so I think that’s where we’ve lost really. When [subsequent head of department] was consultant here and she took early retirement last year, so it means that we just have [new consultant] heading up the service, who’s a very nice chap, but isn’t remotely, remotely interested in [women’s health], by his own admission, he isn’t remotely interested. He supports us but he doesn’t really want to have a great deal to do with it so we’ve lost the drive. (Doctor, TL, line 88)

One of the demands of providing the “drive” is vociferously defending complementary therapy services when they are under attack, particularly when funding crises threaten.

Certainly at the end of the three years when it was being looked at being developed into mainstream delivery, yes I really hope I stuck my neck out. I hope that's why it continued...here you've got someone who is prepared to stand up and say - I think we should do this - and lead the way and fly the flag for it, then things will develop. Where someone is not quite so confident in doing that, not prepared to stick their neck out then that's when the services tend to get pushed on one side. (Doctor, WW, line 59 & 137)

So service champions are crucial to the creation and development of NHS complementary therapy services.

Thus far in this chapter, I have provided details on the two services and their development. I have argued that these services are subject to great vicissitudes, which may be endured more successfully if a respected clinician is strategically placed to champion the service within local commissioning agencies.

Having explored the theme of 'description and history of services at case sites' by describing the two case sites as I encountered them, I will now move on to the theme of 'structural factors influencing service design, delivery and survival' by detailing the structure of an 'ideal' NHS complementary therapy service.

5.3 Structural factors influencing service design, delivery and survival

In brief, NHS professionals appear to be more favourably disposed towards clearly targeted services with specific therapies for specific conditions or populations of high priority where current treatments are limited, ineffective or non-existent, in essence, services that mimic those within the NHS with which they are already familiar. A 'NHS acceptable' service would incorporate mechanisms to regulate demand and be accessible, affordable, well-known and open to outside scrutiny. In addition, it would be precisely targeted to less affluent individuals with high health needs without picking up previously unmet need. Such a service would cost less than existing interventions and demonstrate an appreciable impact on reducing NHS costs elsewhere. These points will be discussed in the following sections.

5.3.1 Specific therapies for specific conditions or populations

NHS professionals are more likely to endorse services that offer specific therapies for specific conditions or populations. In short, NHS professionals find the ‘holistic’ tenet of complementary therapies, whereby the person rather than the condition is treated, bewildering. Having been educated to link particular treatments to particular conditions, they struggle to break free of this concept.

Because NHS professionals think this way, a service which is set up with a limited number of therapies for specific conditions might be more acceptable. For instance, a commissioner gave an example of how acupuncture could be part of a wider service for addictions.

Acupuncture, we know that in other agencies it's used in helping people over drug misuse and alcohol misuse. It's known to be, or it's been shown to be, quite effective. So if it was being targeted at those people, then we'd say well that is something we would want to support.... But we're not likely to develop an enhanced service for complementary therapy; it would be an enhanced service for a specific condition which may include complementary therapy as part of the service. (PCT manager, CB, line 43)

It was just this model that was used in the second site. Only three therapies (aromatherapy, reflexology and homeopathy) were provided specifically for two types of women's hormonal conditions. The service was not available for all women nor for all hormonal problems nor was there a multitude of therapies on offer, even though other treatments such as herbal medicine, acupuncture and nutritional therapies anecdotally all have beneficial effects. Instead, they offered three therapies for two related conditions for one well-defined population.

This model also eventually became the ‘modus operandi’ at the first site, once the PCT took over funding. The service changed from providing about ten different therapies for any condition to offering osteopathy, chiropractic and physiotherapy for musculoskeletal conditions.

But in offering specific therapies for specific conditions not just any therapy will suffice. Ideally, therapies should be selected on the basis that NHS professionals believe:

- There is little or nothing else available for the condition within biomedicine.
- The therapies “work”.

- The therapists delivering treatments are “safe”.

5.3.1.1 Little available in biomedicine

If biomedicine cannot offer anything, because conventional treatments do not exist, biomedical options have been exhausted or bring on unpalatable side effects, then NHS professionals may be more inclined towards complementary therapy services, as these doctors from the two case sites who referred extensively suggested,

I mean as a medic, it's sometimes quite hard to understand it [homeopathy]....But I'm prepared to go with it and just, because I know I can't do much more from the normal medicine point of view. (Doctor, SP, line 175)

Well I think it [the complementary therapy service] gives us another option for people. Instead of saying go away and take these tablets or go away and we'll refer you for physiotherapy, it does mean we can say – go along and see one of the therapists and see where you can get to really. (Doctor, HC, line 32)

In fact, in the case of the doctor who was now practicing homeopathy, lack of viable alternatives in biomedicine was a major draw.

And I'd been doing general practice about, probably about seven years when it finally occurred to me that I actually wasn't doing very much to help the patients recover, to heal themselves... and I thought - there's a limit to this in conventional medicine, there are areas I can't do anything to help my patients. And because I was born and brought up in Calcutta and I knew about homeopathy, I started to think about other ways maybe that I could help patients. (Doctor, TT, line 006)

Complementary therapies can offer patients options, when little else is available. Other studies have also found this (Astin *et al.* 1998; Hills, 2005; Shaw *et al.* 2006a).

Complementary therapy services may also be attractive when conventional services exist but are overstretched. At the first site, several doctors appreciated the complementary therapy service as an “easy referral outlet”, as the physiotherapy waiting list was six to nine months. In fact, being an easy referral outlet may override other considerations, such as a perception of lack of evidence. For example, one doctor made about half of her referrals to manipulation therapies, which she believed had better evidence base, but the other half were to therapies such as massage, aromatherapy and acupressure. Perhaps having easy access to a service, which at best

might make a difference and at worse kept patients occupied, could have been even more persuasive than “good” evidence.

The situation in which there is a little or nothing viable to offer in biomedicine has recently been coined as an “effectiveness gap”. Effectiveness gaps are defined as areas of clinical practice where current treatments are not fully effective and complementary therapies have been shown to have some benefit (Fisher *et al.* 2004). Early research into effectiveness gaps consisted of surveying GPs to identify several potential ‘gap’ conditions, including musculoskeletal, depression, eczema, chronic pain and irritable bowel syndrome (Fisher *et al.* 2004). More recently, the Smallwood report developed this further by mapping the evidence for several more therapies onto conditions such as:

- Homeopathy for upper respiratory tract infections, middle ear infections and headache
- Herbal medicine for osteoarthritis (phytoldor), chronic venous insufficiency (horse chestnut) and dementia (ginko biloba)
- Acupuncture for migraine and stroke rehabilitation (Smallwood, 2005).

Implicit in this approach is the reassuring concept of a specific complementary therapy for a particular condition. However, the Smallwood report still caused controversy amongst the medical community, for example by suggesting there is an effectiveness gap in the treatment of asthma (Thompson and Feder, 2005) (see also rapid responses Ravichandran, 2005 and Leavitt, 2005). Identifying which conditions have effectiveness gaps is for further debate.

Furthermore, the “gap” condition chosen should be wide enough to impact substantial numbers of patients. In comparing the process of mainstreaming counselling to that of complementary therapy services, a PCT manager partly attributed the success of counselling to the perception that counselling can help many patients.

The numbers of cases coming to a GP who could be diverted, if that's the right word, to counselling is probably a much higher proportion. Because although in total complementary therapies might be as big as counselling, it's actually complementary therapies is made up of tens, twenties maybe hundreds of different interventions for particular purposes. Whereas counselling is a nice general intervention that anyone who's a bit unhappy or a bit unsure about their life or a bit non-specifically ill at ease or feeling

ill, might, you know you might think - ah well I can offer counselling to this personAnd it could be applied to a much greater proportion of need than a specific complementary therapy can. (PCT manager, BC, line 41)

By suggesting that complementary therapies are “made up of tens, twenties or hundreds of different interventions”, this particular PCT manager reveals his fundamental confusion about the way in which complementary therapies work, despite his own personal experiences of use. Most therapies employ the same intervention for a range of conditions; not many different interventions for a range of conditions. There is also an irony here. Because complementary therapists work ‘holistically’, based on the individual rather than their symptoms, they see themselves as generalists. But NHS professionals, with their mindsets of specific treatments for specific conditions, view them as specialists, for example acupuncture is ‘good for’ pain. To secure a position within the NHS, complementary therapists may need to shift their healing identities from a holistic generalist to an ill-fitting specialist paradigm, but without whittling away their patient base. Not only could this be challenging, but for many patients and therapists, the attraction of complementary therapies is precisely their holistic approach.

5.3.1.2 Perceptions that the therapies work

Another factor that persuades NHS professionals to endorse complementary therapy services is a belief that the therapy under consideration “works”. This has different meanings for different people.

For some, ‘working’ means patient benefit but it is immaterial what triggers that improvement. A doctor at the women’s health clinic acknowledged that in the complex field of women’s health, not only could complementary therapies have a strong ‘placebo’ effect but biomedicine may have as well.

I happen to feel very strongly that if you get a placebo effect, does it matter really if it is placebo if people are feeling better? That’s the whole thrust of what we are trying to do is to make people feel better.... And I have to say I think there is probably quite a lot of that in complementary therapies, but there is in the way in which I work as well. It’s giving people the confidence that I think they are going to get better. And so quite often they do. (Doctor, WW, line 103)

For others, 'working' has a more medical definition; it means the therapy is perceived as having a clear, specific effect rather than a placebo or non-specific effect. Both clinicians and NHS managers tended to polarise therapies as "effective" or "wacky", "therapeutic" or "stress-relieving", or "efficacious" or "talking". Although there was debate in classifying particular therapies, generally osteopathy, chiropractic and acupuncture were more likely to be considered as having a therapeutic effect beyond placebo.

Part of what contributes to the perception that a therapy 'works' is a mechanism of action that makes sense, as is the case with counselling.

I guess there are some things that may have made it [counselling] more acceptable to mainstream clinicians, the kind of things like - it's not a black box. Clinicians think they understand what counsellors do. I don't think most clinicians think they understand how homeopathy works. (Doctor, PS, line 103)

In considering complementary therapies, as one clinician put it

[With] musculoskeletal conditions I'm much more comfortable with somebody seeing a chiropractor, osteopath, an acupuncturist....I suppose in my semi-scientific way I kinda think - right that kinda relates to the condition the person has.... I think they are so much closer to the Western paradigm of medicine, certainly the osteopathy and the chiropractic. (Doctor, PS, line 21)

Interestingly, acupuncture is often classified as "effective", even though its mechanism of action is poorly understood and the intervention makes little sense in Western terms. However, as one doctor explained, this might be due to anecdotal reports, a long history of use and a perception of robust clinical evidence.

I no more understand acupuncture than I understand reflexology but there is such a wealth of experience and I think research as well in the field of acupuncture to show that the therapy is therapeutic. (Doctor, BM, 36)

In addition, for some a logical mechanism of action is a precursor to making the mental link between a particular complementary therapy and the condition under consideration. For example, a nurse said she might suggest Buteyko (which aims to improve breathing) as a possible treatment for asthma, because she associated a therapy addressing breathing with asthma, but not other therapies, because she "wouldn't connect the two". (Nurse, M, line 73)

If NHS professionals do not understand a mechanism of action (and feel they need to), then clinical evidence may reassure them that the treatment genuinely brings about a specific therapeutic effect. For others, even therapies with 'rational' mechanisms of action may require clinical evidence. Consequently, an ideal 'NHS acceptable' complementary therapy service should have some sort of clinical evidence base, despite many biomedical services lacking the same.

But the level of acceptable evidence may be lower than supposed. For example, at the site offering homeopathy for women's health, the only clinical trial evidence included in the original bid was a review of homeopathy stating that the effects of homeopathy were over and above placebo (Linde *et al.* 1998). This study did not link homeopathy to women's hormonal conditions. But another paper did, which quoted figures from an unpublished audit of homeopathy and women's hormonal conditions undertaken at the Royal London Homeopathic Hospital (Katz, 1997). No evidence at all was offered for the aromatherapy and reflexology service. Thus conceivably, one or two positive trials, or possibly even an outcome study, rather than a substantial Cochrane review, might suffice. This conclusion is supported by the experiences of providers from the Glastonbury complementary therapy service who recently found that commissioners were satisfied with the UK BEAM trial alone as "evidence" for osteopathy (Welford, 2006).

In my study, the data also suggest that in some cases services might still obtain NHS funding without citing specific clinical evidence. In initial drafts of the bid for the revamped service at the first site put forward in 2006, I could find no mention of research literature. This was confirmed by the PCT manager responsible for drafting the bid (personal communication, RS). This supports findings in the previous chapter that there is a discrepancy between the rhetoric of policy makers and commissioners and the reality. Perception of "good" evidence rather than the actual clinical evidence itself may be influencing decision-making and other factors play an important role.

Furthermore, once a service was set up, some NHS professionals in this study were happy with relatively little "evidence" to sustain their convictions. For example, at the second site when asked how they knew homeopathy "worked", the administrator said it was because the doctors had told her; and the doctors said it was because the women did not come back. Interestingly, none of the doctors mentioned the MYMOP audit

(see 4.4.1) as influencing their perceptions of benefit. Of course there may be many reasons why the women do not re-use the service besides the resolution of their symptoms, but no evaluation had been conducted to determine these.

However, this untested faith may be unusual. In conversations with those providing NHS complementary health services elsewhere (Get Well UK, Impact, Glastonbury Health Centre, CHIPs), NHS professionals have required regular proof that the service is making a difference, both in terms of health status and NHS cost pressures. The attitude of the women's health clinic professionals at the second site is probably rare.

5.3.1.3 Safety

Although most of the NHS professionals in this study discussed whether complementary therapies worked, fewer expressed concerns about safety. This could be because the complementary therapies selected may have been seen as largely "safe". Of those who did mention safety, a doctor talked about the low side effect profile for complementary therapies in general. Another said she needed a research base to reassure her about herbal medications, especially as extracts are not standardised. This suggests again that NHS professionals turn to clinical evidence for reassurance when an aspect of a mechanism of action, in this case the lack of standardisation, does not make sense.

I think I'm quite cautious about herbalism for the simple reason that I think a lot of the products out here haven't had a research base behind them. When you go from one herbalist to another, you might be getting what appears to you to be the same preparation, but in fact might have different active ingredients from one to the other, and yet the patients are spending an awful lot of money there. So, I think I feel more positive about homeopathy for the reason that I see that the substances are plant based; they're safe; they're small quantities and so I see it as something that one can very well integrate with conventional medicine. (Doctor, TL, line 54)

Interestingly, she did not require evidence of safety on homeopathy, which also has a mechanism of action perplexing to most doctors, because she perceived it as less likely to interact with biomedical treatments. In addition, I would suggest that she understands the homeopathic consultation better, which also neutralised fears about safety – but that point will be developed later.

Of greater concern than safe interventions were safe therapists. Several NHS professionals in this study mentioned that it was important that therapists were reputable, expressing an underlying fear that therapists may prey on susceptible people.

I would just like to know that hopefully they are not abusive relationships. And you can have an abusive relationship with a mainstream clinician, so I don't excuse general practitioners from that either. But I would hope that on the whole a lot of these people are very vulnerable and it worries me if they are going to see somebody who has had no training and no registration. (Doctor, PS, line 109)

This quote supports Wahlberg's argument that the source of these fears is increasingly

...shifting from an epistemological field of competing theories about health and illness towards an ethical field of practitioner competency, qualifications, conduct, responsibility and personal professional development (Wahlberg, 2007).

Moreover, some make an interesting point that these fears are raised whenever provision is privately financed, not because of qualms about complementary therapies *per se* (Budd and Sharma, 1994; Humphrey, 2004).

Regardless, these concerns do clearly demonstrate that to endorse complementary therapy services, some NHS professionals need reassurance that the therapists themselves are safe. At both sites, this was acknowledged by only employing trained therapists registered with a recognised professional body. In reflecting on why the NHS was less supportive of complementary therapies than nurse led services, a manager mentioned the issues of training and regulation.

We have some trust in our ability to assess the professional capability of a nurse. You know she's a nurse, but she's a nurse with a particular level of training who's registered, who we know can then gain extra skills through further training and accreditation to particular diplomas etc. So I think we have a confidence in nurses' ability to do a professional job. [I'm] not saying that's always fully rightly placed but that is the, so we've got control systems, if you like, on the quality of the professionals' capability. (PCT manager, BC, line 65)

As only chiropractors and osteopaths are currently registered, this leaves the vast majority of complementary therapists on the 'at risk' register, although acupuncturists and homeopaths are working towards regulation. However, based on the experience of chiropractors and osteopaths, who are still not mainstreamed despite fifteen years as

registered professionals, my belief is that registration, on its own, will make little difference in furthering the mainstreaming agenda. Others are similarly sceptical (Boon *et al.* 2003; Saks, 2003b).

So, in developing a 'NHS acceptable' service, NHS professionals are more likely to accept the model of a small number of therapies for specific conditions, when little or nothing else is available in biomedicine. The therapies should be perceived as effective and the therapists as safe. In the next section, I will provide further details of this type of service.

5.3.2 Services features

In designing a 'NHS acceptable' complementary therapy service, the service needs to be targeted to high need, low income patients with mechanisms in place to regulate demand. In addition, the service should be affordable, accessible, well known and evaluated.

5.3.2.1 Low income, high health need

Ensuring that NHS complementary therapy services are for those who cannot afford complementary therapies privately and have high health needs was a concern at both sites, but especially at the first.

As a community renewal project based in an economically disadvantaged neighbourhood, addressing inequalities was a strong ethos. Evaluation and annual reports include numerous quotes from therapists and patients grateful for the access the service provides to complementary therapies. Local health commissioners were also aware of the importance of redressing inequalities.

I think one of the issues is that when we are talking about equality around health. People in more affluent areas have access to a range of alternative therapies because they can pay for them. And because they are probably more aware of what's around. If they know people who've had them, they can be put in touch with therapists. There's a lot easier access in terms of people's choice and health. So in an area like [case site 1], you know people don't necessarily have the options to access complementary therapies because there might not be people in the area offering it. They might not be able to afford it. (PCT manager, BJ, line 51)

An annual report confirms the marginalised status of many service users at the first site: 33% were on benefits; 21% were of pensionable age and 13% were lone parents. Twenty two percent came from black and minority ethnic backgrounds, although the neighbourhood as a whole had a non-white population of about 10%. The report also suggested that many were in considerable health need, as 50% of them found their condition affected a daily activity; a third (32%) had suffered their condition between 1-5 years and over a third (36%) had had their condition for more than five years. Despite this, in interviews PCT managers expressed concerns that the service was missing the “most needy” (sic).

But again, this disparity seems to come down to definitions – in this case of who is considered “needy”. Although the service obviously catered well for old aged pensioners, those on benefits and non-white groups, there were no data on teenage mothers or people with addictions, both high priorities with local PCT managers. For another high priority group, refugees and asylum seekers, data were provided and showed that only 2% of service users made up this category. But limited service use by this and other high need groups might be due more to the preconceptions and consequent behaviours of potential referrers.

For example, in an informal conversation, a nurse told me that many of her patients were refugees with high health needs and little English, for whom complementary therapies seemed wholly inappropriate. In a taped interview later, she gave further details of the type of patient she would refer,

~ *Somebody who is probably British and fairly articulate and interested in medicine. And probably from a professional background. (Nurse, AL, line 15)*

In essence, she seems to be describing someone who is fairly middle class, of which there was sparse representation in this regeneration neighbourhood. Consequently, perhaps unsurprisingly, referral data revealed that she had made no referrals. No one else in this study articulated the same concerns, but they may be shared more broadly. If this is the case, how can the service demonstrate its ability to meet the needs of the worst off, if clinicians, who associate complementary therapies with the middle classes, do not refer them? PCT managers might prefer that NHS funded complementary

therapy services are used to treat the economically disadvantaged, but the prejudices and preconceptions of referring clinicians might be a barrier to this occurring.

5.3.2.2 Mechanisms to regulate demand

To ensure the ‘right’ people are accessing the service in the ‘right’ numbers, measures are needed to regulate demand. PCT managers worry that demand for complementary therapy services could easily outstrip supply.

I think any introduction of complementary therapies has to be incredibly disciplined. And so we need very clear protocols that say this is the sort of case, this is the sort of need that we’re going to meet through this service. Not a ‘come all ye’. (PCT manager, BC, line 81)

At the first site, there were few such mechanisms. Anyone who wanted access to the service could receive treatment. Self-referrals, who made up about a third of the referral base, had only a perfunctory assessment process, in which severity of condition was not addressed. For the first four years, before NHS professional only referrals, it was definitely a “come all ye” service.

In contrast, at the women’s health clinic, self-referrals were even higher (70%) but many patients first saw a nurse and all patients had to see a doctor to access the complementary therapy service. Doctors saw this as crucial in rationing demand, providing continuity of care and ensuring that appropriate patients used the service.

I think it works, I think it’s essential. It’s perhaps a screening process in that it does control who gets to the homeopathist, and there’s some feedback, so we’ve got a history and some idea of what’s going on. (Doctor, SP, line 109)

GPs don’t have direct access to homeopathy. So they can’t refer directly, so this is to our advantage that they have to come to us, their patient has to wait for such a long time. If the GP could refer directly maybe they could be seen quickly by them and the other thing is that some of the GPs, I’m not saying all of the GPs, don’t know much about [women’s health condition] and then sometimes after discussion we find out that the problem is something else. (Doctor, SH, line 74)

But there is considerable irony in medical professionals functioning as gatekeepers to complementary therapies. Apart from questions this raises about power, many are ill-equipped to make these sorts of judgments, as a therapist from the first site commented

So we had to sort of educate the GPs really, which I found quite surprising....You know you had to ask for a GP, you know the GP to allow you to treat this person and I thought – well, that's strange because they didn't, they didn't seem to know very much about the therapies. (Therapist, MM, line 80)

Another way to control flow is through referral guidelines. In the first site, referral guidelines existed, but they were never mentioned in interviews and appeared not to be a major influence in referral decisions. Conversely, at the second site, referral criteria were etched in stone. When asked about the characteristics of patients referred to the complementary therapy service, all of the doctors gave the same response, even though the document detailing the referral guidelines had long since disappeared. This clarity was probably due to the nature of the criteria themselves; women who were not candidates for pharmacological interventions were allowed access, as were women who specifically requested it. Referral criteria clearly set out who the service was for.

5.3.2.3 Well known service

Obviously, clinicians are unlikely to refer to the service if they do not know the service is available and who is allowed to refer. This was not a problem at the women's health clinic as during induction, new medical staff observed the homeopaths and referral guidelines were constant. However, as the service developed at the first site, the criteria for those permitted to refer altered as the financial crisis deepened. Moreover, with a large number of potential referrers, constant turnover and a service based across two surgeries, ensuring that the service had a consistently high profile at the first site was more challenging.

A doctor, who had been in post for about two years at the time of the interview, said that the service was well publicised in the locum handbook. But, publicity may not be enough. For example, a nurse who was a six month locum said

Well it wasn't that I wasn't aware. It wasn't flagged up. It wasn't promoted enough unless I probed and stuff like that. (Nurse, AL, line 37)

Once the service co-ordinator spoke at a nurses' team meeting, this particular clinician fully appreciated that she could refer. Some potential referrers may need personal contact, in addition to promotional literature, before referring.

5.3.2.4 Accessible and affordable

Having access to local complementary therapy services which their patients can afford is very important to some clinicians. For instance, a doctor at the first site recounted that before her current position, she worked in a rural practice in Yorkshire. The closest complementary therapists were 25 miles away. So, although many of her patients might have had the money for treatment, the therapists were too far away for the doctor to feel comfortable referring.

Several years later, she had access to complementary therapies 'in house', but still she only made one referral. For the first six months, she felt relatively negative about complementary therapies. For a variety of reasons (not to do with the service) that attitude began to change. But about the same time, the service encountered financial difficulties and patient fees rose from £5 and £3 (employed and unemployed respectively) to £10-15 and £5.

I'm much more loathe to send people now because I know it's only £20 or something for a session but for a lot of people that's prohibitive. And that definitely has put me off. (Doctor, PS, line 57)

Accessibility and affordability were also concerns for a doctor at the second site. After the aromatherapy and reflexology service was stopped in January 2006, this particular doctor still suggested aromatherapy and reflexology treatments for her patients, but instead of giving them the contact details of the nurse/ therapist who had previously provided this service on site, she preferred sending clients to the local beauty school nearby.

People express a wish for aromatherapy, for people to see [nurse therapist] privately, but it's expensive. And I find that the clientele that we see, it really is outside what they can afford. But we're very fortunate here because we've got a very good beauty school just round the corner from us and they provide quite a few complementary therapies there...and because it's a training school then they'll offer it at £5 to £8 a treatment so it's affordable. And you know, I've got to be honest with you and say that if I see somebody and clearly money is going to be an issue, I'll give them the leaflet to go round the beauty school rather than [nurse therapist] which is £25 to £30 a session. (Doctor, TL, line 44)

So, in this case, a personal relationship with the therapist, who was also a nurse, held less sway than a cheaper service nearby. For both these doctors, local, affordable services were important precursors to referrals.

However, an osteopath thought that local accessibility and affordability were “excuses”; the real reasons behind non-referral were more hidden.

Yes, and usually the excuse is, we're private practice, it's not provided for by the NHS. That wasn't an excuse when I was working there [GP surgery. I was still getting no patients. (Key informant, osteopath, JP, line 386)

5.3.2.5 Evaluations

The purpose of evaluations in a ‘NHS acceptable’ complementary therapy service, at least from data in this study, is ambiguous. Rhetoric insists that evaluations be carried out, but in practice, it appears that evaluations may have little effect on changing attitudes amongst NHS professionals; indeed they may not be read at all.

In both services, evaluations were undertaken. In one, despite glowing interviews with nearly 30 patients and staff, the evaluation was deemed inadequate by local health commissioners. In fact, the relentless optimism of the report appeared to repel at least one PCT manager, who thought it was biased. In contrast, an enthusiastic clinician said that it confirmed his belief that the service was “a pretty good health intervention”. In this case, the evaluation report did not appear to move either sceptics or champions, as both maintained their initial positions.

In the other site, a comprehensive report covering health status and referral information was written. Aimed to support an application for further funding, it is not clear whether the publication of the report happened before, during or after the decision was made to extend funding.

I don't know what happened to it [evaluation report] after [it was written]. Probably not very much. It might have been used. By then, I was moving upwards and I think so other people were taking on the role and I'm not sure if they were interested enough to use it unfortunately. (Doctor, WW, line 191)

Thus, decisions about further funding could have been made without commissioners consulting the report, even possibly before it was produced. Furthermore, future annual reports sent to the local PCT went unacknowledged. Yet the two homeopaths were adamant that producing regular evaluation reports was “very powerful”. In this

case, it appeared that the act of producing information may be sufficient, possibly to demonstrate the professionalism of the therapists involved and their willingness to be scrutinised. The reports themselves might not inform decision makers.

The lack of a discernible effect of complementary therapy service evaluations on NHS professional attitudes and decision-making at these two case sites is probably not all that uncommon. In exploring the relationship between evaluation reports of NHS complementary therapy services and funding decisions across the UK, I found the link between the two was tenuous at best (Wye *et al.* 2006). For example, the authors of a published study on a homeopathy service in Coventry noted that the decision to cut the service was made before publication of evaluation results. This was despite the aim of the evaluation being to inform funding and the demonstration of a positive impact on both health status and NHS cost pressures (Slade *et al.* 2004). In the case of the Glastonbury study, health commissioners “refused to continue its [the service’s] funding, in spite of the very positive results of the evaluation” (Hills, 2005). Another study of the interaction between researchers and commissioners in designing and evaluating a complementary therapy service found that the evaluation had more effect on building relationships than decision-making (Warburton *et al.* 1999). But, despite the apparent lack of impact of evaluations, for ‘NHS acceptable’ complementary therapy services they seem to be universally expected to monitor quality and performance.

So, in summary, in addition to targeting specific treatments for specific conditions, a ‘NHS acceptable’ complementary therapy service should concentrate on high need, low income patients and regulate demand through mechanisms such as referral criteria and gatekeepers. Moreover, a ‘NHS acceptable’ service would be locally situated, affordable for patients and regularly publicised through informal or formal contacts between service providers and referrers. Finally, a ‘NHS acceptable’ service would be regularly evaluated, even if those reports are not read or fed into decision-making processes.

5.3.3 High priority

But all those ‘NHS acceptable’ features are futile if the complementary therapy service does not address NHS priorities, either by targeting national or local priority health conditions or populations or by addressing NHS financial pressures.

5.3.3.1 Condition or population priority

Gearing service development towards local and national priorities permeates every level of NHS commissioning. To obtain funding, PCT managers have to write bids for existing and new services. These are granted by internal committees or external agencies, like the Department of Health. So, PCT managers become adept in marketing services in terms of priorities. One explained,

At the moment, I know we have no money for enhanced services. Everything that I do is going to be on a pilot basis. So I'm trying to build that into [the bids]. And I know that the priorities for the PCT have been drug misuse, sexual health, alcohol and some sort of mental health. (PCT manager, CB, line 89)

She constructed her bids to address local priorities as they had a better chance of success.

But unfortunately, complementary therapy services are not a high priority. Furthermore, if they are combined with low priority conditions or populations, they are vulnerable to cuts. This was the situation in the second case site.

Everyone in the NHS, they're looking much more at teenage pregnancies and all those figures that are figures, whereas the [middle-aged] lady doesn't come high in the profile in the NHS....She's not a target; she's not a number; she's not anything. She's very important to the family and everything else at home, but not in the NHS....In the scheme of things, we're very much out on a limb really. We're low priority is the [women's health] clinic, and so homeopathy is probably even lower in that it's just an extra to our clinic. (Doctor, SP, line 287)

Women with hormonal problems are low priority, as are complementary therapy services, so despite the high value accorded to the homeopathy service, when financial cuts were needed, it was discontinued.

Low priority status means that no one is asking health commissioners to consider complementary therapy services generally.

We don't have the same sense of responsibility for developing complementary medicine. Most things have got national frameworks, a national guidance, a national expectation or national targets. Complementary medicine hasn't. So it's in that sense it's more fringe still to us.... We're not having to hit particular targets or implement particular government policies. (PCT manager, BC, line 13)

This manager went on to explain how a national agenda on complementary therapies could affect local priority setting.

Those things that get heavily promoted and then incentivised nationally are often the things that do develop. So, now whether that's done in softer ways through collaboratives and development teams that come in and help develop it. So you could have a complementary therapies development team.... So you could have that sort of national intervention that's quite soft or you could have a harder one that says by 2006 you will all have introduced acupuncture for headaches or whatever, which is another approach that does happen as well....Because it's a target and it'll affect our star ratings and so on. So the whole performance management system kicks in against a target, in favour of a target. So if government decides that it really is important to develop a more effective set of interventions, introduce some effective interventions that are known to be effective, cost-effective, perhaps as well as popular, then it can do it. (PCT manager, BC, line 85)

So, without a national steer, health commissioning agencies have few incentives to develop complementary therapy services locally.

5.3.3.2 'Add on' or 'instead of'

What does interest local commissioners, however, is the potential for complementary therapy services to reduce NHS cost pressures, including prescription costs, primary care consultation rates and dependency on secondary care.

The more we can reduce reliance on secondary care, the more we'll see community developing. The more we develop community services that are effective at reducing hospitalisation, the less we will need to use hospitals. So I think if we could pick up the things that really make a big impact on people's hospitalisation rates or outpatient, use of outpatient clinics, they will get, they will be seen to be popular....The real lever unfortunately to this [mainstreaming of complementary therapies] will be the reduced use of hospital care. (PCT manager, BC, line 89)

So it is not enough for complementary therapy services to demonstrate good patient outcomes, they also need to show that patients reduce their use of other NHS services.

We've only got one pot of money. We haven't got enough money to meet our current needs. So it's save to spend. Never mind saving £50 here and spending £50 there. It's not about taking money out of the system. It's about saying we've only got one pot of money and we've got to use it the best way. (PCT manager, RA, line 44)

“Save to spend” is a mantra amongst NHS commissioners. Complementary therapy services do not need just to be effective, they have to be more effective at improving health status than current services, cost less and save money for the NHS elsewhere. But demonstrating this has not yet been achieved. To date, the little evaluation data that exists shows variable results. (see 4.4.1)

5.3.3.3 Unmet need

There is another catch. Not only do complementary therapy services have to demonstrate effectiveness superior to current interventions, cost less and save money in the NHS elsewhere, they have to avoid picking up unmet need. In interviews, it became clear that “unmet need” had many different meanings such as:

- Those suffering potentially dangerous conditions such as high blood pressure without knowing it
- Those who were aware of their condition but did not seek treatment either because they were managing it themselves or because they were ignoring their condition
- Those who were aware they had a condition, sought treatment but no services were available
- Those who knew they had a condition, sought treatment and services were available but services were substandard or ineffective

With regards to complementary therapy services, PCT managers emphasised that services have to be geared for patients whom the NHS is already treating rather than those who are currently outside the system.

This is a difficult concept to grasp. For example, it means that a patient with low back pain having physiotherapy counts (as hospital costs are incurred), but someone with the same condition who is under ‘usual care’ (i.e. occasionally visits their doctor but generally makes no more demands) does not. Ideally, complementary therapy services should treat the former but avoid the latter. Picking up unmet need is a real concern, as the NHS is already under severe financial strain.

In fact, most of our community developments are at risk of picking up on that need as it is. So, if we had the respiratory nurse, we’ll probably find more people with wheezes and so being seen that wouldn’t otherwise have been done because they wouldn’t have

been serious enough to get a hospital appointment.... Now that's an issue for us about whether we're expanding the boundaries of NHS capability and NHS priorities because we're making it more available. That's already an issue for us and I think there is a concern that complementary therapies would take that even further. (PCT manager, BC, line 77)

So local health commissioners may be interested in complementary therapy services if they believe the services deliver treatments that are more effective than current interventions, while costing less and reducing pressure in the NHS elsewhere, but all that has to be done without “expanding the boundaries of NHS capability”. This might be setting impossible hurdles.

5.4 Factors that did not influence service design, delivery or survival

Having described the theme of ‘structural factors influencing service design, delivery and survival’, I will temporarily set aside the question of whether such a service could actually exist and instead consider other aspects, beyond structural features, that might influence key gatekeepers to endorse complementary therapy service provision. But before presenting those that appeared to work in convincing clinicians, I will first consider several that appeared weaker than anticipated in developing the theme of ‘factors that did not influence service design, delivery or survival’.

Before undertaking fieldwork, I believed that line management by health commissioners would be an indication that a complementary therapy service was more mainstreamed and by association, more highly valued and stable. At the first site, around three years after the service was launched, I was able to test this assumption, as the service became line managed by the Public Health Department. It made little difference, as a PCT manager predicted.

I wouldn't say it [line management responsibility] made us [the PCT] more committed.... I'm not sure we can say just because we are managing the staff we would necessarily say - yes we can pick up £100,000 a year without any difficulty. (PCT manager, CB, line 61)

In a funding round later that year, although commissioners did earmark £3,000 to cover the rent of the office, which they might not have done otherwise, further funds were refused. Line management responsibility did not lead to much increased support.

Another potential influence that could have positively affected NHS professionals' attitudes towards complementary therapy service provision was personal experience. The power of personal experience to change 'hearts and minds' instinctively makes sense and was put forward by some study participants. For example, the chair of the original service steering group believed that taster sessions persuaded GPs to include shiatsu after their initial reticence, although a therapist said that nurses, rather than GPs, usually attended these sessions. Furthermore, a nurse who had used relaxation and massage said:

It [using therapies yourself] makes you more aware and I think if you've had a benefit then you're more likely to pass it on and say actually well this worked for me. Have you thought about it? And you become less sceptical if you've had a good experience with it.
(Nurse, M, line 121)

Despite this avowed support for complementary therapies however, I could find no record of this nurse having referred to the service.

I found other evidence to cast doubt on the influence of personal experience. For instance, on the whole, the doctors who regularly referred to the women's health complementary service at the second site said they had very little personal experience of complementary therapies. Of the three therapies offered (aromatherapy, reflexology and homeopathy), one doctor had used aromatherapy and reflexology, while none had tried homeopathy, despite this being the most popular therapy of the three. Two doctors had never used any complementary therapies at all, although one did have a daughter who was a physiotherapist trained in acupuncture. The one who had had treatments in reflexology and aromatherapy was not particularly effusive about her experiences. In contrast, a fourth doctor was fulsome about her seventeen year treatment with a chiropractor. Overall, however, within this service, I was surprised to find only one doctor with extended personal experience of complementary therapies and many without, yet they were all uniformly enthusiastic about the homeopathy service.

In the first case site, I also found the relationship between personal experience and referral behaviour confusing. Two doctors, who had the most positive attitudes and were responsible for nearly 200 referrals between them, had limited firsthand experience. One had had chiropractic treatment himself on one occasion. Another had

tried some shiatsu and osteopathy since the service was set up, but said that his interest in complementary therapies pre-dated these treatments. Another doctor, who had had about the same level of experience of complementary therapies as these two, made only one referral.

Conversely, a nurse, who had experienced extensive beneficial treatment with homeopathy, called herself a “cynic” and made no referrals. Another nurse, who spoke very positively about her own treatment experiences, also referred no one. Moreover, four of the seven directors of the local PCT had some experience of complementary medicine, as they either were users themselves or had partners who were complementary therapists. Yet despite this personal experience, as an organisation they were reluctant to fund complementary therapy services.

Perhaps this schism is because people separate their personal and professional selves; they may have had beneficial treatments personally, but their professional behaviour is regulated by other codes. In fact, one NHS professional did differentiate between his “personal” and his “personal professional” beliefs. (PCT Manager, BC, line 21) Of course, I am not saying that personal or family use of complementary therapies does not make any difference at all, but these data do suggest that there is not a straightforward relationship between personal experience, whether beneficial or not, and subsequent referral behaviour. It is more complicated.

Moreover, complementary therapy services appeared to make limited impact on changing attitudes, despite some commentators suggesting complementary therapies can actually transform biomedical practice (Peters, 2002; St.George, 2004). When asked if the service had changed her attitudes, one doctor responsible for 10% of the referrals at the first site said,

No, probably not very much. I had the sense before that osteopathy and the physical therapies were useful and referring people has confirmed that. But I don't think it's altered my attitude to the less evidence based therapies. (Doctor, BC, line 31)

Another doctor, who referred extensively, said,

I don't think I actually know any more about complementary therapies really. I can see the benefit of it because patients do really like it and they can see the benefit, but actually I haven't done any more reading about it. I don't know any more about the evidence about whether it works or not. (Doctor, BM, line 54)

At the second site, doctors reported that the homeopathy service had made them more “open”, but it neither changed their own clinical practice nor increased their use of complementary therapies personally.

I can say it changed my view about complementary medicine but not my practice. My practice is the same what it was. But yes, I am referring patient[s] to the homeopathy because I know I can refer patients and this is available so I am referring. There is not much change in my practice. (Doctor, SH, line 156)

But a therapist said she would not have expected this.

There's no direct contact with the [women's health] doctors. I don't work at the same time. The homeopathic medicines are put in a box and they're kept actually by the administrator, so they don't see our paraphernalia...We're not crossing paths on a daily basis and they're not seeing our stuff on a daily basis. (Therapist, RR, line 247)

So, overall, access to complementary therapy services appears to have limited impact on attitudes, but even less on behaviour.

Similarly, patient reported benefit had a mixed effect. At the first site, some patients clearly believed feedback influences NHS clinicians.

Well, physically it [acupuncture] did make a difference because I was quite seriously anaemic. And there was an improvement. And when I went back to the national health doctor because I found out through tests that the doctor had done that I was anaemic. And then she checked me again. And it showed that there was a marked improvement. And she said to me, “How did you do it?” (Patient, XM, line 23)

Therapists also thought positive reports made a difference.

One of my patients told me last week that he'd been to see Dr B and she had been going to give him anti-inflammatories, and when he said he was coming to see me she said, “Oh well, I'll leave it and see what the acupuncture does first.” And I think this is, for her, I think this is a big change from when the project first started. So that's nice because they've been getting feedback from our patients. So yes, maybe the doctors are coming round. (Therapist, LK, line 549)

One doctor did link his increasingly positive attitude to patient reports, along with an evaluation.

Since I've been involved with referring patients and having that freedom and hearing about their views of it and through the [evaluation], my feelings have moved from ambivalence to a much

more positive feeling that this is something that the community really wanted. And it seems to do a lot of good. (Doctor, BP, line 22)

But good patient feedback may have confirmed growing positive attitudes rather than sway the unconverted. Reluctant professionals seemed less moved.

Well it's a popular service with the patients. I think that's important. And they do feel it's another resource for them. And I think a lot of them do value it. But probably for the reasons I've said, there is less time pressure and they are being heard by somebody else really. (Doctor, HC, line 40)

Patients might appreciate the service, and derive benefits from it, but that may not convince unsympathetic clinicians.

This finding - that patient reported benefit may make limited impact on unreceptive clinicians - rather conflicts with the findings of the previous chapter that patient experiences can have an impact on the decision making of NHS professionals. This might be because NHS professionals apply one set of criteria and decision-making behaviours to biomedical interventions and another to complementary therapy treatments. So, for example, if a patient reports a positive experience with a pharmacological agent, a clinician might be more willing to be persuaded of its benefit as pharmacological interventions 'fit' with his or her understanding of illness and disease. But a positive patient report of a complementary therapy intervention might be more easily dismissed, because of a sceptical clinician's preconceived attitudes towards complementary therapies.

In summary, I found several factors that did not influence NHS professionals' attitudes and behaviour towards complementary therapies, as I thought they might. These included: NHS line management responsibility, personal use of complementary therapies by NHS professionals, exposure to a NHS complementary therapy service and patient reported benefits. The next section develops the theme of process factors that did influence service design, delivery or survival.

5.5 Process factors influencing service design, delivery and survival

5.5.1 Commitment to patient centred care

The values of the referrers' themselves, and the systems they operate in, appeared to affect attitudes towards complementary therapy services. In particular, I found doctors at the second site were more receptive to complementary therapies, because they worked within a personal and organisational framework that prioritised patient experiences and preferences.

For instance, the complementary therapy service came about in response to patient demand and any woman who wanted access to complementary therapies received it. Moreover, this commitment permeated other aspects of the service, from the consultation process to the service structure. Every clinician interviewed spoke about the importance of allowing the women themselves to select their preferred treatment. This was reflected in the patient pathway.

So we [the nurses] would invite a group of women to come...and we would talk to them about the [condition], what it is, and self-help, including herbalism, homeopathy, aromatherapy, reflexology, diet - phyto-oestrogen diet. We'll give them lots and lots of information for a couple of hours. And then...some of them would go away and say, "Well I think I can manage it myself. I'll go to the herbalist, I'll take a phyto-oestrogen diet, I'll change my lifestyle." Others would say probably "I'd like homeopathy," others aromatherapy, reflexology, and some would say, "I'm so desperate I'm going on [drug treatment]."If they wanted to come to the clinic, if they wanted to see [reflexologist] or the homeopathist, they then had to go and see a doctor....So then they see the doctor and then the doctor and the patient together would decide because they were informed, you know, "Well, you've been to one of the meetings, what would you like?" (Nurse, TH, line 134)

Both in-house and external options were explored; both complementary and biomedical treatments were discussed. Before patients made a choice, they were properly informed. But educating patients takes time, which was limited for doctors at the first site.

The thing with general practice particularly is that we are very time pressured. You know we can't spend half an hour or an hour with people. (Doctor, HC, line 36)

Like a colleague from [surgery] said, "Thinking about a complementary therapist is the last thing in your head". You know the last thing you can think about, there is so much else going on. Time I think. Consultations there feel very, very pressured. And I don't often feel I get time to think things through properly. Maybe if I did, the [service] would be higher up. (Doctor, PS, line 57)

But doctors at the second site were less time pressured as they allowed thirty minutes for initial consultations and fifteen for follow-ups at three monthly intervals. In fact, in many ways, the doctors' clinical practice was similar to that of complementary therapists - too much so for some.

[Under the first head of service], the ladies attending it became quite chronic attendees and you know, there were a certain group of them that came along almost like a coffee morning because this was my doctor and if [that doctor] wasn't here they wouldn't see anybody else. So, you know, they became quite dependant upon [that doctor], and as I say, it got a bit of a reputation for we were dealing with every blessed problem that they had in their lives. Apart from anything else, I didn't really want to be part of that type of service. (Doctor, TL, line 38)

"Chronic" attendance and treating "every blessed problem" are hallmarks of complementary therapy care. So this brings up an interesting dilemma. On one hand, complementary therapy services offer NHS patients more time and stronger relationships with healthcare providers, which studies of patients suggest they want (Shaw *et al.* 2006a; Shaw and Evans, 2006). Yet when the NHS system allows for this, patients can become too "chronic" and the service created is unattractive to some NHS clinicians. So how patient-centred can NHS services genuinely be? This point will be further elaborated in the discussion chapter.

5.5.2 Under the same "umbrella"

The doctors at the second site may not have understood the mechanisms behind homeopathy, nor been able to explain its principles, but they did regard the homeopaths as an integral part of the team. This was influenced by their observations of homeopathy consultations, through which they came to understand the treatment process and recognise patient benefits.

Whenever I first came along to do this [women's health] work, that I actually spent time with [homeopath] and sat in with her, seeing her patients and I think it is really valuable that because it gives

you an understanding of actually how the homeopath works, you know, how they really go through their decision-making process and yes, I found that really valuable and I think, yes, it is really a useful thing for people to do. (Doctor, TL, line 75)

Therapists also found their observations of biomedical consultations were useful forums to discuss homeopathy.

I have sat in with a lot of the doctors. I've gone and spent a morning in clinic with them so that I get to see more what they do and understand the system, and they get a chance to, and they've also used that time to ask me about what I do. (Therapist, RR, line 69)

Mutual observation did not occur with the clinical psychologist.

We also use a psychologist, a clinical psychologist alongside us, who is very valuable, [name]. But unfortunately, she isn't happy for people to sit in with her session and you can understand that because obviously it has to be a very definite interaction between she [sic] and the client. So it's unfortunate really from that point of view, because it means we don't have quite as much understanding of the way she works, you know, she provides an information leaflet, but it's not the same really, is it, as being able to see the actual consultation process taking place. (Doctor, TL, line 75)

But although doctors did not understand clinical psychology fully, it still sits firmly within mainstream practice. Hence, not observing consultations may affect their attitudes less. But this was not the case at the second site for the aromatherapy and reflexology service. Doctors did not sit in on these consultations; consequently they did not understand the therapeutic process and were more likely to dismiss it as “just talking”. In fact, one linked her lack of referrals to insufficient “experience” of this therapy.

I have not much experience in that thing [aromatherapy / reflexology]. I don't used to refer [sic] that many patients at that time. (Doctor, SH, line 84)

In addition to educating the doctors and demonstrating the value of the therapy, mutual observations of consultations meant that homeopaths came to be trusted and were viewed as under the same healthcare “umbrella”. Relationships were strengthened, and for one therapist, relationships were identified as pivotal in the NHS.

Being in the NHS, I think is a very Kafka-esque experience... and finding who is actually in charge of something is actually quite difficult.... And at the beginning, I took that very personally and

thought it's because it's homeopathy, it's because it's homeopathy it's a marginalised, fringe, wacky discipline....But now actually my perspective is completely different. I think actually {laughs}, [it's] the whole way the bloody system works. The whole system is in some sort of chaos and depends on personal relationships and trust. (Therapist, RR, line 103)

She may be right. Doctors from both sites reported that personal relationships influenced their referral behaviour.

I think I'm a little bit cautious in terms of knowing who I'm referring people to. So I like to have gone along, have met the person, or else know through reputation that this is a reputable practitioner. (Doctor, TL, line 60)

Now it may be because of my part time role at [surgery] but I haven't met any of the [service] therapists and I like to meet people and then I think I'd feel much more comfortable about saying, "You know what I think? You should go and see [X] about this. Why don't we arrange a referral and this is how we can do it."....And actually I'd feel more comfortable if there were other practitioners that I thought 'yeah fine they're kinda under the umbrella - we're all part of the same group', but I think seeing people as colleagues is important. (Doctor, PS, line 125)

Perhaps clinicians at the second site clearly came to regard the homeopaths as colleagues under the same umbrella because the four key elements to forming and sustaining an integrative team identified by Mulkins and colleagues were present including: 1) effective communication 2) personal attributes such as being a "team player", imparting enthusiasm and having a "pioneering" approach, 3) satisfactory and commensurate compensation for the work carried out, 4) a supportive organisational structure (Mulkins *et al.* 2005).

Developing strong relationships may be easier in services where there are a limited number of therapists. One GP at the first site identified the profusion of therapists as a major barrier to building relationships.

You know we do refer but part of the problem is that there are tons and tons of therapists, many of which do few hours. It's hard for us to get to know any of them particularly well and build up a professional relationship. (Doctor, BP, line 62)

In this study, I found exposure to NHS based complementary therapy services was not enough for NHS professionals to perceive therapists as colleagues or for professional relationships to develop. These attributes were more apparent at the second site and

appear to have been generated through mutual observations of consultations. But what if the therapist is a medical professional themselves? Would that confer automatic collegial status? Others have written about this (Adams, 2000; Thompson, 2005), but data from this study is less conclusive.

None of the therapists at the first site had biomedical training. In contrast, at the second site two of the three therapists had biomedical backgrounds. In fact, the professional homeopath identified the medical status of her homeopathic colleague as a key ingredient of the success of the homeopathy service. Moreover, one doctor confessed that she was more “comfortable” with the medical homeopath. But interestingly, the aromatherapy/ reflexology service provided by the nurse was not so highly valued. So, possessing a biomedical qualification may help, especially in establishing the service, but it would not be sufficient for NHS clinicians to endorse a complementary therapy service. It could be that doctors are more respected than nurses, hence the reasons that the medical homeopath was more highly esteemed. Nonetheless, drawing any definitive conclusion on the basis of only two practitioners is unwise.

5.6 Summary

5.6.1 Main findings

This chapter began with the ‘description and history of development of services at case sites’. A key finding was that the establishment and maintenance of complementary therapy services in the NHS depends on the engagement of a well-placed individual (ideally a doctor) with leadership qualities, who has contacts and knowledge of PCT commissioning processes.

I then explored the theme of ‘structural factors influencing service design, delivery and survival’ and outlined the structural features of a ‘NHS acceptable’ complementary therapy service. NHS professionals are more likely to endorse a complementary therapy service that mirrors what they know. Such a service would offer a few select therapies, chosen on the basis of perceived effectiveness, for specific conditions of high priority or populations of high need. The service would be affordable, accessible, well known and evaluated. Mechanisms to regulate demand would be in place and the

service would cost less than current interventions, save money elsewhere in the NHS and avoid previously unaddressed need. But an acceptable structure is only one element in winning over NHS professionals.

A subsequent theme identified factors that I anticipated would make a difference and did not, while the final theme discussed 'process factors influencing service design, delivery and survival'. They included the development of good inter-professional relationships and the perception of complementary therapists as "under the same umbrella", which appeared to be facilitated at the second site by observation of complementary therapy consultations. A shared healthcare philosophy, such as a commitment to patient centred care, may also increase the likelihood of NHS professionals valuing the contribution that complementary therapies can make.

5.6.2 Comparison of themes with existing literature

The themes developed for the meso level topic of service design and delivery have not been previously identified in existing literature on complementary therapy services. Possibly, this is because this topic is so under-researched. However, one study does offer some comparative findings. Luff and Thomas carried out a study of ten complementary therapy services located in NHS primary care in the late 1990's (Luff and Thomas, 1999). Some of the findings from my study concur, while others disagree. For example, Luff and Thomas reported that one service, which provided healing, relied on word of mouth and patient reports, which had resulted in a "sea change" in GP attitudes. GPs agreed that patient feedback influenced them, as did the personal manner of the healer herself, although it is unclear whether GPs had actually met the therapist. In another site, GPs became convinced of the value of Alexander Technique through positive contact with the practitioner and good feedback from patients. Unfortunately, information from the Luff and Thomas study is limited, so we do not know if the GPs who were influenced by the healer and Alexander teacher were already favourably disposed towards complementary therapies or if they became so through contact with these therapists. In this study, I found little evidence that patient reported feedback was sufficient to persuade reluctant or sceptical clinicians, but did reinforce the beliefs of those with already positive leanings.

On the other hand, both this study and that of Luff and Thomas found that “joint consultations” fostered excellent working relationships. For instance, in one of their study sites where joint observation of consultations did not occur, Luff and Thomas found that six therapies were perceived as excessive and relationships were poor between the therapists and between the therapists and GPs. But relationships were “excellent” in another service that offered “joint consultations” between GPs and therapists, even though eight therapists were employed. So, perhaps it is possible to employ more therapists and develop collegial relationships, if joint consultations or mutual observations of consultations take place.

5.7 Conclusion

In considering the thesis question of the alterations necessary to bring about mainstreaming, I have found that many changes, both in relation to structure and process of service design and delivery, would be necessary to create a NHS ‘acceptable’ complementary therapy service. Some of these alterations could be quite straightforward to implement, whereas others would require great fundamental shifts in the philosophies and working practices of complementary therapists. This is discussed in depth in chapter 7. The next chapter explores potential changes to complementary therapy consultations as the micro level topic of this thesis.

CHAPTER 6 Clinical practice

6.1 Introduction

This chapter considers the micro topic of clinical practice, specifically variations between complementary therapy treatments provided in the state funded and private sectors. Whereas the two previous chapters have primarily looked at the concerns about mainstreaming from the perspective of NHS professionals, this chapter focuses on those of complementary therapists, mainly the potential effects of mainstreaming on treatment delivery. The principal question addressed is: What are the differences between complementary therapy consultations delivered in the NHS and privately?

In constructing this chapter, I have drawn on the following data sources:

- Interviews with study participants
- Observations of acupuncture and homeopathy consultations
- Wider reading, especially literature on healing and private biomedical consultations as well as studies of other complementary therapy services, complementary therapy users generally and complementary therapy consultations

From these data sources, several themes were identified and developed in relation to alterations in clinical practice in mainstreaming complementary therapies. These themes are detailed in the table below. For detailed description of how these themes were developed, see 3.5.1, 3.5.2 and Appendix K.

Table 10 Key themes, data sources and process of derivation of theme for micro level topic of clinical practice

Theme	Data sources contributing to theme development	Process of derivation of theme
Patient characteristics	Observations of consultations Literature on private biomedical consultations and surveys of complementary therapy users	Analysis of observations of complementary therapy consultations Reading of literature
Similarities in private and NHS settings	Interviews with study participants Observations of consultations Literature on private biomedical consultations	Analysis of observations of complementary therapy consultations Thematic analysis of study interviews Reading of literature
Differences in private and NHS settings	Observations of consultations Literature on private biomedical consultations and complementary therapy consultations	Analysis of observations of complementary therapy consultations Thematic analysis of study interviews Reading of literature
Differences expected in private and NHS settings but not found	Observations of consultations Literature on private biomedical consultations, complementary therapy consultations and other	Analysis of observations of complementary therapy consultations Thematic analysis of study interviews Reading of literature

	complementary therapy services	
Space and time	Observations of consultations Literature on private biomedical consultations, other complementary therapy services and healing Interviews with study participants	Analysis of observations of complementary therapy consultations Reading of literature Thematic analysis of study interviews

This chapter begins with the theme of ‘patient characteristics’ in comparing the attributes of private and state funded complementary therapy users. It continues with the theme of ‘similarities in private and NHS settings’ and then with ‘differences in private and NHS settings’. This is followed by exploration of the theme of ‘differences expected in private and NHS settings, but not found’ and concludes with the theme of ‘space and time’, two factors that appear to create the greatest variations in clinical practice. Throughout, I argue that the differences between state funded and private consultations appeared to be minimal and largely due to modifications in consultation length.

But before continuing, there is an issue around semantics. Individuals treated with complementary therapies in the private sector are usually referred to as “clients”. NHS clinicians call users of their services “patients”. When therapists treated individuals in the NHS sector, sometimes they borrowed mainstream lexicon and used the term “patients”. Moreover, in this study, some study participants were both “patients” and “clients” as they were treated in both NHS and private settings. Accordingly, I have used those terms interchangeably, along with “user”, throughout this chapter, except when I am referring exclusively to the private sector – in which case I use the term “clients”.

6.2 Patient characteristics

In exploring the theme of 'patient characteristics', surveys have generally found that complementary therapy users tend to be women between the ages of 35-60 with higher educational qualification and greater disposable incomes (MacLennan *et al.* 1996; Eisenberg *et al.* 1998; Blais, 2003a; Thomas and Coleman, 2004). But as 90% of complementary therapy provision is in the private sector (Thomas *et al.* 2001a), these studies are dominated by private consumers; less is known about those who are state funded. To compare the characteristics of state and private users, the following section details user characteristics from those observed in treatments in the two case study sites. In total, ten individuals were observed in fourteen acupuncture consultations and eight were observed in eight homeopathy consultations.

In comparing patient characteristics across private and state funded settings, as well as between the two case sites, I found that:

- Overall more women (n=13) were treated than men (n=5). In the NHS setting, there were seven female and three male patients; privately three women and two men were treated and three women were observed in both private and NHS settings.
- Amongst acupuncture patients, more men were treated in the NHS setting than privately, while with homeopathy, more women were treated in the NHS and more men privately. This is to be expected given that the NHS homeopathy service treated women only.
- The age range across the two sites and between the two types of settings was similar, with only one patient falling outside the age range of 35 to 60.
- All but one patient were white.
- 13 of the 18 patients, whether NHS or private, were employed.
- Known occupations amongst private clients included: vicar, theatre director, housewife/ former nurse, care assistant and former builder. Known occupations amongst NHS only patients included: factory manager, nurse, care assistant, carpenter, shop assistant.

- There was a tendency for private clients to have more professional occupations, although a former builder attended privately, while a factory manager was treated in the NHS. Interestingly, nurses and care assistants were treated in private and NHS settings.

Another issue to consider is type and severity of presenting symptoms. Determining exactly what was being treated was complex, as complementary treatments can work on physical, emotional, mental and spiritual levels simultaneously. With acupuncture, often the acupuncturist, the client and I had different understandings about the focus of the treatment. For example, one client said her treatments were for anaemia; I thought an ear infection was the main complaint and the acupuncturist said that she was working on bereavement issues. Another client requested treatment for insomnia, I thought the therapist focused on dispelling excess liver energy, but after the client left, the acupuncturist remarked that the crux of this case was the client's relationship with his mother. This was a surprise, as during the consultation the acupuncturist only asked one question about the client's mother.

Although the discrepancies were less remarkable between my and the therapist's perceptions on the principal conditions within homeopathy consultations, again identifying the range and type of symptoms and conditions receiving treatment was not immediately obvious. Hence, in distinguishing the focus of treatment, readers should be aware that only my understandings of interactions and conversations observed in one-off sessions are presented; the therapists and clients, who in many cases have worked together much longer, may have very different interpretations.

Table 11 Principal conditions in acupuncture consultations

NHS only	
Patient 3	Back pain
Patient 4	Insomnia sinus pain
Patient 5	Skin infection job stress alcohol dependency
Patient 6	Shoulder & hip pain death of friends housing problems/ poverty
Patient 7	Sickle cell anaemia marital relationship
Private only	
Patient 9	Immunity booster
Patient 10	Ear infection job stress
NHS & private	
Patient 1	Ear infection bladder infections
Patient 2	Groin strain immunity boost pregnant teenage granddaughter
Patient 8	Loss of sensation in abdomen

Table 12 Principal conditions in homeopathy consultations

NHS only			
Patient 11	Low libido	vaginal dryness	hot flushes
Patient 12	Hot flushes	night sweats	
Patient 13	Hot flushes	tinnitus	arthritis
	high blood pressure	heartburn	constipation
Patient 14	Breast pain	mood swings	marital problems
Patient 15	Mood swings	low libido	death of a friend
Private only			
Patient 16	Low immunity	fear of heights	lack of energy
	Relationship with mother & siblings		
Patient 17	Insomnia	motor neurone disease	in wheelchair
Patient 18	Hot flushes	asthma	dermatitis

In examining these data, I concluded that in this study:

1. NHS acupuncture patients were more likely to experience physical conditions such as sickle cell anaemia and pain in backs, shoulders and hips while private acupuncture clients received treatments for ear infections and lowered immunity. Those individuals who experienced both NHS and private consultations required treatment for conditions such as bladder problems, groin strain and abdominal complaints.
2. Unsurprisingly, as the homeopath observed was a specialist in female hormonal conditions, many of the patients suffered from hormone related symptoms.
3. The client most severely debilitated by his condition was the former builder with motor neurone disease who now used a wheelchair. He was a private homeopathy patient.
4. NHS acupuncture and homeopathy patients appeared to have somewhat more complex circumstances, often with multiple physical conditions in addition to emotional or social problems, but this was not solely the preserve of state funded patients.

5. Two of the 14 acupuncture consultations were primarily focused on immunity boosting, as acupuncturists often recommend that clients have a treatment every few months when the seasons change. (personal communication, therapist LK and acupuncture user, KK) This reflects the use of complementary medicine in promoting self-care and prevention of illness.

Having explored the theme of patient characteristics, the next section considers the theme of similarities in private and NHS settings.

6.3 Similarities in private and NHS settings

When exploring differences, similarities are often overlooked (Silverman, 1987), hence the importance of noting and reporting them. In observing acupuncture and homeopathy treatments in both settings, the structure of each consultation was broadly consistent.

In acupuncture consultations, the therapist would begin with a general question such as “how are you?” and the client would either talk about recent activities or describe physical symptoms. After discussion of their physical condition, the acupuncturist usually would steer the conversation into more sensitive areas such as emotional, social or financial difficulties. Occasionally this was initiated by the question, “How are you in yourself?” Sometimes the acupuncturist would suggest dietary changes (avoiding wheat or alcohol), exercise (walk at lunchtime, chi gung classes) or other sources of help (nutritionist, housing benefit). The therapist often examined the client’s tongue while the client was still seated in the chair. Once the client had partially disrobed and was on the couch, the acupuncturist usually checked pulses and then told the client what she planned to do. Often, after inserting a needle, the therapist would check that the client had felt “the electric pulse” which indicates that a point has been correctly needled. When all needles were inserted, the therapist would wash her hands. Then sometimes she would sit quietly or leave the room or she would slowly circle moxa around the needles while the client rested. Occasionally, once all the needles were inserted, the acupuncturist would start a conversation into a more intimate topic but often there was silence. After the needles were extracted, the therapist sometimes rubbed oil into the points and occasionally massaged the client’s head, shoulders, back, legs or feet. The client then had a few minutes to dress, while the acupuncturist replaced the couch

paper, tidied away any remaining needle papers and put all used needles in the sharps bin. The client would pay, arrange the next appointment, thank the acupuncturist and leave.

A typical homeopathy consultation would begin with the therapist asking about the source of referral (for new clients) or ascertaining when the last consultation took place (follow up). With new clients, the homeopath would outline the structure of the session, give a brief explanation of homeopathy and complete a form with contact and medical history details before asking about presenting symptoms with a question such as “what would you like help with?” For returning clients, she would enquire about symptoms since the last visit and sometimes ask for specific details of how and when prescribed remedies were taken. Topics usually covered in both first and follow up consultations included: sleep, dreams, general health, appetite and digestion, bowel movements, relationships with family, thirst and MYMOP. Other topics occasionally discussed included conventional medication use, update on areas discussed in previous consultations and use of other complementary therapy treatments.

Occasionally, when the consultation was relatively advanced, the homeopath would ask, “So what do you feel you need help with now?” In drawing the consultation to a close, the homeopath would either prescribe a remedy with instructions or would say that the client would be contacted once a remedy was selected. If a prescription had been made, the client would take the first dose before leaving the consulting room. Sometimes the homeopath would refer clients to potentially relevant reading material, other types of health professionals (for example counsellors, allergy testers) or in one case suggest that the client should drink six glasses of water daily. The client would complete a MYMOP form and schedule the next appointment. Usually, as the client was leaving, the client would thank the therapist but sometimes the therapist thanked the client first.

Overall, similarities in both state funded and private acupuncture and homeopathy consultations were so extensive that without knowing where the treatment had taken place, I would not have been able to guess. Differences between the two were marginal. In identifying and isolating these, I continuously reflected on whether the difference was attributable to setting or to individualisation of treatment. However, before

presenting the differences from my perspective, the following section begins to explore the theme of ‘differences in private and NHS settings’ from the perspectives of therapists and patients in interviews.

6.4 Differences in private and NHS settings

6.4.1 Differences noted by therapists

Overall, therapists noted more differences between settings than patients. However, while at least one therapist mentioned every point below, not all would concur with each observation, as their individual experiences varied substantially. With that caveat, therapists commented on differences across settings in patients, premises, time, equipment, relationships, money, clinical autonomy and treatment delivery.

In considering differences in user characteristics, a therapist commented that NHS patients were less knowledgeable about complementary therapy treatments and consequently more time in initial consultations was taken to fully inform them. Several noted that NHS patients were more likely to suffer from serious physical and social conditions and have greater medication use.

[Private clinic patients are] usually people that are massively busy, self-employed or high pressure jobs, whereas the stress of [NHS patients] is due to their life circumstances and not having work, not having any money, yes the opposite, and family problems and housing problems, they live in a block of flats and they don't get any sleep because the person next to them is up all night, and drugs and people visiting the house all the time, music playing. (Key informant, JP, line 158)

NHS premises were sometimes noisier with people talking outside and footsteps in corridors. They also could be more basic with greater security devices such as bars on windows and locked doors.

I was going to say about the security because it was always locked up, because of drugs and things....It's just really weird to be in a practice where I worked through the morning and then you finish lunch time and I may still have a patient and the whole place is barred up and so you just have to use the back exit, take the patient through, where all the doctors and nurses go, show them out the fire exit. (Key informant JP, line 114)

Constraints, especially those of time and equipment, were more apparent in NHS settings. The number of private consultations was unlimited, whereas in NHS settings, the maximum was eight (site 1) or six (site 2). For some therapists, consultation times in the NHS were reduced, especially for homeopaths, who usually spent 90 minutes in first consultations and 60 in follow ups privately but were limited to 60 minutes for initial consultations and 20-30 minutes for follow ups. But other practitioners, such as osteopaths, increased their NHS consultation times by 10-15 minutes to carry out administrative tasks. Private consultations were more likely to over-run, especially if no other clients were scheduled. It was harder to obtain equipment such as essential oils through NHS supply chains, as there was no precedent in the requisitions system.

One therapist felt that private clients had greater expectations than NHS patients.

I think they expect more if they come private.... I think they are more impatient with their treatment, because each time they have to pay they will re-evaluate whether it's worth it, whereas with NHS patients, they just, they're more likely to just go, "okay well, I'll try this and see what happens" and it'll be longer before they evaluate whether it's worth their time. (Therapist, RR, line 211)

This therapist also felt that boundaries were better in NHS consultations.

I've got clear boundaries with them, whereas with my private patients, sometimes I get tangled up....It's partly that women [with hormonal complaints], I'm now very familiar with and their issues, so, you know, I've worked out any boundary issues that were there, and there's also the wonderful edifice of the NHS, which you can hide behind, you know, the bureaucracy. (Therapist, RR, line 203)

Another, who worked as a nurse and a therapist, believed that relationships between practitioners and clients were more equitable in private consultations, but patients revealed more in NHS consultations.

The women would tell you a lot more when you went in a uniform [as a nurse]. Although I didn't wear a uniform at [GP surgery] or [GP surgery], I think they still looked at me as the 'the therapist' and they were 'the patient', whereas if you go into somebody's home you are more woman to woman. So it's more an even thing. (Therapist TH, line 268)

A study of private homeopathic consultations also found that clients believed their relationship with their therapist was more balanced than their relationships with NHS clinicians (Chatwin and Collins, 2002).

The nurse/ therapist quoted above was the only study participant who mentioned money, commenting that private consultations were better paid. She also felt that private therapists have greater freedom to work more flexibly, but perhaps she was comparing this to her experience as a nurse in the NHS.

Several therapists mentioned differences in treatment approaches. A homeopath said she prescribed higher potency remedies in the NHS. An acupuncturist noted a tendency to “over treat” in the NHS, defined as inserting more needles than usual. She also found some treatments such as “yin strengthening” easier to do for clients at home. An osteopath said he focused more on self-care measures with NHS patients. But only one therapist mentioned feeling less effective within the NHS, and interestingly, this particular individual had also worked as a doctor in the NHS and as a private homeopath.

I don't think I'm as effective here [in NHS]. I'd like to be more effective. There are times when I know I'm not effective and I know it's because of the time loss and I'll start again from the beginning and bring them in because I know that's what's wrong. I've not been able to get into the case because of the time factor. (Therapist, TT, line 282)

6.4.2 Differences noted by patients

Unlike therapists, the patients who were interviewed - all of whom had experienced treatments in NHS and private settings - initially identified no differences between settings. With further probing, some patients re-considered, but the differences were minor.

For example, in interview one acupuncture client found that private clinic sessions felt more like pampering than those she had experienced in the private home setting or the NHS.

When I went to see her at [private clinic] I felt as though it was a very cosmetic exercise if you know what I mean --- acupuncture, and that was really strange because of all the times that I've seen her and the different places that I've seen her in, I really did feel a bit like, as though I was going off for a massage or a facial. (Patient, XC, line 142)

Another acupuncture client commented that the therapist asked more “psychological stuff” in private consultations and that the client tended to lie for a longer time with

the needles inserted in the private home setting, which may have had an impact on effectiveness. A third acupuncture client definitely felt there was a difference in effectiveness, in that positive benefits were generated faster and remained longer in private home consultations because of use of an infrared lamp, not available in the NHS setting.

It's just that when she's using the lamp, it's warmer for longer, if you know what I mean. Rather than use the little stick thing [moxa]....And also it warms up quicker with the lamp. (Patient, A, line 28)

Despite this, this client still preferred receiving treatments in the NHS for practical reasons - it was closer to her home. A fourth acupuncture client thought that the quality of the treatment in the two settings was the same, but that the therapist's home was more comfortable.

In contrast, the homeopathy clients, with the exception of one client who commented on the restriction of six sessions, tended to note differences in premises and location only. All three homeopathy users, who had experienced both private and NHS treatments, commented positively on the pleasant surroundings of the private clinic, but nonetheless, convenience of location rather than quality of physical premises was prioritised. Two clients preferred the private clinic because it was closer to their homes, but another preferred to attend consultations in the NHS as the clinic was closer.

6.4.3 Differences noted by the researcher

During my observations of consultations in private and NHS settings in the two case study sites, I noted four differences which were not mentioned by any therapist or patient. The first is that clients were accompanied by family members (spouse or children) in two of the eight private consultations, while patients alone attended the fourteen observed NHS consultations. Silverman and Strong also found that private clients were more likely to be accompanied (Silverman, 1987; Strong, 2001).

The second is that in the NHS setting, acupuncture patients completed MYMOP forms in initial consultations as part of ongoing service monitoring, whereas private clients did not. Although the homeopath did use MYMOP in private consultations as well as in the NHS, and for every consultation, this is unusual and could be because she had an interest in research.

The third is that private home acupuncture clients experienced a greater range and number of procedures, partly because the therapist had more equipment at home. For instance, one private home client received needling on her front, needling on her back with moxa and then cupping. In total, the client had four procedures. In discussing this, the acupuncturist commented that she was able to perform two sets of needling with some NHS patients but tended not to use cups, the infrared lamp or certain types of moxa because that equipment was not transported to the NHS setting.

Another difference, again identified from my observation of acupuncture consultations, was that some NHS patients disrobed without being asked. In two of the nine NHS acupuncture consultations, patients took off their coats, shirts, skirts or shoes before sitting down in their underwear to converse with the therapist. This never happened in any observed private consultations. The acupuncturist commented in an interview that this had only happened once before in the home setting - to her annoyance. Her explanation for this behaviour amongst NHS patients is that they were conscious of time constraints. Although this is possible, undressing is common in GP consultations and I believe patients transferred their previous biomedical experience into the context of acupuncture treatments. Undressing in somebody's home however, would seem rude, unless explicitly invited. This interpretation is supported by the therapist's negative reaction when this occurred in her home practice. Perhaps biomedical mores operate at a more subtle, unconscious level in NHS settings than either therapists or patients recognise.

6.4.4 Differences identified in detailed analysis of observations of consultations

Despite the differences identified above, in general, therapists, patients and I agreed that variations in clinical treatments between the two settings were minimal. To test this further and gain greater understanding of the similarities and differences, I carried out additional analyses with a matched pair of NHS and private consultations from each therapist.

6.4.4.1 Homeopathy

Before presenting this analysis (full details available in Appendix E), a brief description of the matched homeopathy patients follows. The first homeopathy patient, called Julie (pseudonym), was observed in the NHS. She was 58 years old and suffered from a variety of conditions including tinnitus, arthritis, prolapses, high blood pressure, constipation and frequent viruses. Although she was having herbal treatment at her local GP surgery and took numerous prescription medications, she sought homeopathy for problems with decreased libido, hot flushes and sweating. Julie was married with two adult sons and worked as a care home assistant for the elderly.

The second homeopathy client was observed in a private clinic. Named Lucy (pseudonym), she had been referred by a doctor at her local surgery, who also worked at the women's health clinic where the NHS complementary therapy service was based. As a member of a private health insurance scheme, half the fee was reimbursed. Lucy was 50 years old and also had numerous complaints including asthma, contact dermatitis, fibroids, joint problems and back pain. Unlike Julie however, Lucy considered herself healthy. She was seeking treatment as she could not take medication for hormonal conditions and was suffering from night sweats and hot flushes. Married with one grown up child, Lucy, like Julie, also worked as a care assistant.

Despite different clients being treated in different settings, there was a surprising degree of similarity between NHS and private homeopathy sessions (see Appendix E). Most remarkably, the two consultations finished within 30 seconds of each other. Many topics such as menstrual history, family health history, referral route, current health status, dreams, fears and phobias were covered in each setting. In some cases, the homeopath used the exact same words to elicit information e.g. "run me through a typical night". Throughout each consultation, she repeatedly prompted "anything else?" The forms used in each setting, a patient information form and MYMOP, were identical. The therapist wrote down the remedy prescription in each case and gave similar instructions for contacting her between treatments.

But, the variations are also interesting. In terms of topics discussed, most differences were client initiated (holidays, exercise, herbal medication use, psychic ability) or client specific (caffeine intake, bladder habits, combining different types of medication). The private client experienced a physical examination for a skin complaint, while the NHS

patient did not. The NHS patient was given an information sheet on homeopathy, while the private client was not. At the private clinic, the remedies were stored outside so the homeopath left the room, while remedies were carried into the NHS consulting room. The NHS setting was much noisier with six episodes of external noise, one of which prompted the patient to raise her voice, while in the private setting, outside noise could only be heard twice.

The other notable difference, which is not due to setting but to homeopathic individualisation, is the remedy prescribed. Despite having similar symptoms, the two women were given different remedies for different reasons – sepia for one and folliculinum for the other. Sepia was given for the mental picture of Julie's psychic abilities and love of the sea, while folliculinum was prescribed for Lucy's physical state to address previous artificial hormone use. The process of remedy taking also differed; sepia was to be taken three times a week for four weeks while only two folliculinum tablets were to be ingested over a 24 hour period. Furthermore, the follow up time varied, in that the private client was asked to return in four weeks, while the follow up consultation for the NHS patient was set for three weeks.

In commenting on a previous draft of this chapter, the observed homeopath said that the standardisation of her clinical practice across NHS and private settings was deliberate. In establishing her NHS practice, she realised that she could provide good quality treatments within NHS time restrictions and so reduced her private consultation times to keep both in line.

If I can do it in an hour in the NHS, then I can do it in an hour in my private clinic.... I couldn't afford to be self-indulgent with my time. (Therapist, C from field notes 26.3.07)

Hence, she was unsurprised that the consultations so closely paralleled each other.

6.4.4.2 Acupuncture

Whereas the similarities between the homeopathic consultations in the two settings were remarkable, variations between the two matched acupuncture sessions were greater (full details available in Appendix E). This was despite the fact that it was the same client being treated for the same condition, rather than two different clients being observed, as was the case in the homeopathy consultations.

Alice, the patient whose NHS and private consultations were selected for this analysis, is described in the first chapter of this thesis (see Chapter 1). She was seeking treatment for a lack of sensation in her abdomen following a Caesarean section over 10 years previously.

Broadly, the similarities between the two matched acupuncture consultations included:

- Tongue and pulse diagnoses
- Needling of the abdomen
- Twisting of needles
- Application of moxa
- Physical examination
- Healing silences (defined as two minutes or more after all needles are inserted when both the client and the therapist are quiet)
- Washing of hands by the therapist
- Client payment
- Client re-booking in two weeks time

It was relatively quiet in both settings. Both treatments aimed to strengthen abdominal muscles, but the NHS treatment also addressed a recent symptom of blocked sinuses. The NHS consultation was more physically demanding, partly because the therapist attempted to treat the sinus condition and also, without access to the infrared lamp, the therapist had to create heat herself. So, she applied healing energy to the client's face, scraped the client's abdomen and regularly circled needles with moxa. Unlike the private session, where the therapist sat down several times and left the room on two occasions, in the NHS consultations her only respite was for two minutes mid-consultation while writing notes. Since this patient followed four previous NHS patients and this was a particularly demanding treatment, perhaps it is unsurprising that the therapist showed signs of fatigue.

Some of the differences between the two settings were due to factors other than the use of the infrared lamp in the private consultation. The private consultation was more sociable: the client's daughter was present, there was some initial chat about skiing holidays between the four of us, the therapist showed the daughter different types of needles as they whispered about acupuncture and the client hugged the therapist at the

end of the consultation. However, the festive atmosphere could have been because Christmas was a few weeks away.

Both consultations over-ran; the private treatment by nine minutes and the NHS by five minutes. The private consultation was 14 minutes longer than the NHS consultation. Two and half minutes of small talk, an extra five minutes of needling time (46:00 privately compared to 41:35 in NHS) and over three extra minutes of healing silence (25:04 privately compared to 21:44 in NHS) may account for some of that variation. Although roughly the same number of needles were inserted, it took longer in the NHS setting to complete the procedure (19:40 in NHS compared to 8:41 privately). The client rested longer in the private setting once all were in place (28:39 privately compared to 21:55 in NHS). The impact of increased exposure to needles on health outcome is not known; it appears to be a subject of debate (Campbell, 1999).

So, the analysis of paired consultations leads to the same conclusions as the key findings from interview data - differences between the delivery of treatments in the state funded and private are minimal. Where setting specific variations are noted, they tend to be attributable to time and space. But before exploring these further, I will consider the theme of 'differences expected in private and NHS settings but not found'.

6.5 Differences expected in private and NHS settings but not found

Interestingly, apart from one therapist, no interview participant volunteered source or quantity of money as a notable difference between treatment settings, perhaps because it was too obvious. In probing the impact of personal financial contributions during interviews, some considered the quality of service and noted no differences between settings, whereas others reflected on the potential of personal financial contributions to enhance commitment to the therapy or motivation to change unhealthy behaviours.

If you pay, it's the commitment. I'm coming from the patient's side up to the payment thing...It's much more a taking control thing, deciding how you're going to spend your money....It's like I will take control of my life....This is my decision. This is my money and I'm going to spend this on my health. (Patient, XC, line 294)

A: I don't ask for 15 [pounds] with most people [in the NHS setting]. I've only asked one person so far.

Q: And why did you decide 15 would be [the right amount]?

A: She's giving up smoking. It helps the motivation. (Therapist, LK, line 417)

But encouraging motivation and commitment through payment has its limits.

Q: Some therapists believe that when patients pay they're more likely to get better because they've invested more in their treatment and they're more motivated. Do you think that's true?

A: No, no, because when I used to go to the homeopath, he's always telling me I should stop smoking or I should stop drinking.... I said, "I know but I'm sorry this is how I'm coping." So even though I was paying him I wasn't totally taking his advice. (Patient, XC, line 286)

Interestingly, this is the same patient quoted previously, who remarked that direct payment increases motivation. Therefore, while some may argue that personal financial contributions influence commitment to health, neither clients, therapists nor I as an observer could identify any differences that were directly attributable to money. Instead, as one therapist noted, private sector fees are inextricably bound with private sector premises. This is addressed in the final theme of this chapter, 'space and time', which is explored next.

6.6 Space and time

6.6.1 Space

In this study space came to be defined in several ways:

1. Geographical location of the clinic or surgery
2. Physical premises of the clinic, surgery and consulting rooms including décor
3. Room allocation
4. Topography of the building

Before exploring these, a brief description of the private consulting rooms follows. NHS treatment rooms were described in Chapter 5.

The private setting for the homeopathy sessions was a clinic located near the city centre in a precinct close to a university. A converted semi-detached house, clients sat in a waiting room with natural light while classical music softly played in the background. A

receptionist sat behind a waist high counter and books and nutritional supplements were on sale. A large notice advertised a talk on MYMOP; a poster listed therapies offered at the clinic and an article on the "Power of Homeopathy" was prominently displayed. The whole atmosphere was one of "lush calm" (phrase taken from field notes), despite the steady stream of clients and sporadic ringing telephone.

The consulting room, situated across from the waiting room, echoed this relaxed atmosphere. Large, painted blue and white, with a window, a mirror and many plants, there was a desk and two chairs in a corner, over which hung an angel. A professional certificate (not belonging to the observed therapist) hung on the wall. On the treatment couch in the middle of the room, manila folders with notes were spread out. Although there was some natural light, two lamps at opposite corners of the room provided soft lighting. The room was comfortably heated. Observations took place in February 2006.

In addition to NHS premises, acupuncture observations occurred in two private settings. The first was a clinic located above a shop selling herbs, homeopathic remedies, cosmetics and books. A receptionist sat in a small waiting room where a water cooler and magazines were placed. The consulting room was next to the waiting room, although upstairs there were further treatment rooms and a toilet. The treatment room for the acupuncturist overlooked a busy road at the bottom of a hill and so the sounds of buses and motorcycles changing gear and accelerating were constant. The room was painted in natural colours, with strips of soft green wallpaper, and a neutral carpet. An oversized wooden table and two chairs were next to the window, with another chair opposite. The treatment couch dominated the centre of the room. At the other end of the room (not pictured), there was a sink with a disposable towel dispenser. Next to this, was an alcove where another chair, a stool, towels and blankets and assorted toys and books for children were stored. The room was warm. Observations took place in October 2004.

The second private setting of the therapist's home was much quieter. The acupuncturist lived in an inner city residential area in a three bed, mid-terrace house. On entering the house, a corridor led off to the left into the treatment room that had recently been painted white. With a large bay window overlooking the front garden, the room had plants, bare floorboards with rugs, a bookshelf, a cabinet with supplies and a desk with two chairs by the window. At the foot of the treatment couch was a coal

effect fireplace that was on during treatments. The room was warm and cosy. Observations took place here in December 2004.

As noted previously, while patients generally found private consultation rooms more pleasant, accessibility to the location, rather than the quality of the physical environment, was prioritised. In contrast, the quality of premises was occasionally important to therapists, although one felt that it was largely immaterial.

And I think to a fair extent the physical premises for what I do are largely irrelevant. I think they are for most people any way....If you're giving a really nice relaxing massage then as long as the place is clean and doesn't smell and is warm enough and correctly lit, I don't think it matters whether you're in a concrete bunker which is painted in drizzly black and grey stripes or whether you're in a really lovely beautifully appointed treatment salon. I really don't. (Therapist, XH, line 22)

Another therapist also told me that the impact of the environment was minimal.

We were working in a portacabin at [site one] for the first year; [it] was somewhat oppressive though not as bad as you might think. Looking at it, really at the end of the day the focus is between the two people and what's going on in the treatment. The room isn't that important. (Therapist, LK, line 123)

Yet a patient, who had been treated by this particular therapist, recounted that the therapist had frequently complained about the premises, while the patient herself claimed that the treatment and the therapist were more important than the physical surroundings.

A: Oh she just thought it [the portacabin] was dreadful.

Q: Did she give you specifics?

A: Oh I think, I don't know, the noise, the noise, I think it got hot in there or cold in there, she just found, she just really obviously didn't like the portacabin. But I'd say to her, "It doesn't really bother me." Because I think the thing is I was going for treatment, the couch was the same, she was there, the treatment was the same, and I'm not that kind of person, I'm quite easygoing, that things like that don't really bother me, as long as it's clean and tidy. (Patient, XC, line 132)

Another therapist, interestingly with a nursing background, found the NHS premises so disturbing that she moved buildings.

It's a horrible, horrible clinic, I hated it there. The atmosphere's awful, it's what I call a sick building. The noise outside, I mean,

I've actually been doing a treatment and there's been drilling in the road, there's been cars peeping, there's been ghetto blasters. (Therapist, TH, line 188)

So, although excessive amounts of noise can disrupt treatments, therapists and patients tended to agree that physical premises are largely immaterial to the quality of consultations.

Instead, space appears to have a different impact; it influences the extent to which patients and therapists feel valued. For instance, one patient at the first site preferred the new building, which had replaced the portacabin during fieldwork, because it contributed to her feeling well looked after.

You know if you have physical problems and you go to see somebody to help you, I think it does make a difference to feel that you're worth it in a way. That you are really well looked after. And I think the environment does affect [that]. So obviously it kinda makes you feel good to walk into a nice premise and to see there is good equipment and there is [sic] good facilities there rather than walking into a dingy, little portacabin. (Patient, XM, line 108)

Therapists also equated space, in terms of allocation of consulting rooms, to the value given them and their service.

When I first went there it was a very strange experience. I was up on the second floor and I'd go through one, two - two locked doors with different codes and then through another two doors and then I'd turn right, and I would be in something that actually felt like a broom cupboard next to this tiny loo. I felt like I was in the broom cupboard. I think I felt very hidden, and I was there for about two years so patients would manage to find me, and I felt very sort of like, [short pause] very hidden, very unvalued, but carried on doing what I was doing. (Therapist, RR, line 108)

The connection between quality of premises and perceived worth was also made by doctors and administrators during interviews with those working in both case study sites.

Q: And so who would actually make that decision then [about room allocation]?

A: There's a sort of a service manager really, well, there's a booking system and there's a lot of discussion and debate, who shouts the loudest sometimes... and our homeopaths and the [women's health] clinic would be fairly low in the shouting. (Doctor, SP, line 342)

Well um yes I suppose other people have rooms that [the complementary therapy service] would prefer. But I think when we prioritised it and took a view of all the GPs, I think the GPs think the drug workers are more important than the [complementary therapy] people. You know it's really us deciding that really. (Administrator, F, line 11)

Interestingly, therapists objected to their room allocation because it was next to a large, noisy waiting room; and, as previous findings show, complementary therapists can find excessive noise disruptive.

Therefore, while complementary therapies might be allowed into NHS premises, sub-standard or inappropriate room allocation delivers a message about their value. In a study of a complementary therapy service located in an Israeli hospital, Shuval also found that the consultation rooms were located on the “geographical margins” of the hospital buildings, which symbolised their fringe status (Shuval, 2001).

But room allocation can have another impact; it can facilitate or hinder relationships between complementary therapists and mainstream healthcare professionals. For instance, at the second site, a doctor commented that her relationship with one of the complementary therapists was non-existent because they worked on different floors. A therapist remarked that she now knew other doctors since moving downstairs. Moreover, the relationships between NHS staff and therapists improved when schedules coincided, as room allocation permitted.

When we started off, we deliberately had clinics running at the same time. It might be in different parts of the building but then at least we could see each other.... And there was sort of an informal cross over or you knew that somebody was working so if you had a problem, wait until they finish seeing that woman and then go and talk to them or sort of send a message - I want to talk to you at the end of the clinic about something or other.... It's much better when it's at the same time. (Doctor, WW, line 154)

In addition to room allocation, building layout also fosters inter-professional relationships. One therapist had worked in two NHS GP practices. In comparing the two, she commented,

A: One difference actually was the building itself, which was a lot more conducive to people meeting each other and speaking, having conversations in corridors and things which is nothing to do with the organisation of the project, that's just a different place...

Q: How was the layout different then?

A: It was just the position, I'm talking about the actual practice premises, it just, there was a nice staff room there so it was easy to chat with the physios and anybody.

Q: And was there any staff room [at the portacabin at site one]?

A: There is a little one that was occasionally occupied by a harassed reception person. There's no, no sense of space to make social relationships there at all actually, dreadful from that point of view, it's worse from that point of view than it was from the practising point of view actually. (Therapist, LK, line 365)

Nurses at the first site also identified the importance of social spaces and “mingling” in developing inter-professional links.

Q: And what is it that is necessary to make that sort of integration happen?

A: Well something like an area that we all use, or use together would help enormously.

Q: Like a physical area?

A: Yes, like a coffee room. (Nurse, VL, line 55)

You know certainly in a staff room setting at lunchtime...if they're sitting here chatting over lunch you get to know what they're doing, and it just makes you more aware, they raise their own profile if you like and they don't kind of slip in and slip out again and people kind of think oh, who was that? We've got to recognise them now and so we do, but they don't ever mingle with us and I always think that's a bit of a shame. (Nurse, M, line 145)

But testing the proposition that unplanned encounters can lead to informal relationships and inter-professional referrals is not straightforward. According to interview sources from site one, ad hoc contacts were infrequent in both GP surgeries where treatments were offered. Nor is the second site more helpful. Even though the reflexologist/ aromatherapist moved from onsite to offsite and she noted that referrals decreased, other factors such as her impending retirement might have been more influential. During interviews, study participants, both therapists and NHS clinicians, believed that shared social spaces would lead to greater visibility and use of the services. Intuitively this makes sense, but it cannot be tested further in this study.

Overall, the findings suggest that space, in terms of accessibility of clinic location, is prioritised by patients. Patients are less concerned by physical premises and décor than therapists, as long as noise levels are acceptable. But space confers other meanings,

such as an indication of value, and facilitates social interactions, such as relationships between complementary therapists and mainstream practitioners. So, although space itself does not affect complementary therapy treatments, it may influence the degree of mainstreaming possible.

6.6.2 Time

Another key difference study participants noted between consultations in private and state funded sectors is time. Time and space have an interesting relationship; sometimes the two are used interchangeably to indicate the same concept, such as a quiet pause to reflect. In this study, time had this more ambiguous meaning as well as 'clock' time, or the allocation of minutes to individual treatments. In addition, time was also defined as the total number of consultations.

An obvious difference between time in NHS and private consultations is that in both case sites, state funded treatments were limited in the total number of treatments allowed, whereas private treatments were not. However, none of the therapists interviewed found this stipulation onerous, as in both services the option of extended access was available at the request of the patient.

As mentioned previously, the consultation lengths of the observed homeopath remained consistent across the two settings: 60 minutes for initial consultations and 20-30 minutes for follow-ups. The acupuncturist worked in three settings: two private and one state funded. In her home private sessions appointments were 60 minutes; NHS practice treatments lasted 50 minutes and private clinic consultations were 45 minutes. The acupuncturist chose to timetable her private clinic consultations for 45 minutes as the rent in that particular clinic was high and she needed a steady throughput of clients to meet it. In principle, her private clinic appointments were the shortest and private home consultations the longest. In all settings and across both case sites, the therapists themselves set these consultation times.

The longer appointment times of complementary therapy treatments, compared with biomedical consultations, is a source of controversy. Many believe that any changes brought about through complementary therapy interventions are due largely to longer consultation length (Ernst, 2005; Grossman, 2005) and some studies support that contention (Bikker *et al.* 2005). In this study, a few clinicians at site one also expressed

the view that the therapeutic effectiveness of complementary therapy treatments is a result of lengthier consultations.

And I think it's been proven with a lot of complementary therapies or a lot of non-NHS treatments that what people value is time and feeling that they've been heard. (Doctor, HC, line 36)

A nurse expanded on this by suggesting that the sense of value patients derive from longer appointment lengths is responsible for positive health outcomes, rather than the therapeutic intervention itself.

It's the fact that somebody is taking an interest in them rather than what they [the therapists] are actually doing. (Nurse, AL, line 104)

Moreover, she suggested that if NHS clinicians also offered longer appointments, they too would have this effect.

But I also think that it could also possibly, equally be met by the ratio of staff to patients being better so that we've [NHS staff] got more time for people. (Nurse, AL, 104)

But patients in this study did not agree. They believed that time alone is not sufficient to create positive health outcomes; the interventions themselves have benefit.

Q: Some people think the difference that complementary medicine makes is in terms of the time. That if people had 40 minutes or 45 minutes talking to their doctor, they would find benefit as well. What do you think about that?

A: Well I think that's a bit naive because I don't spend that time talking to [therapist], she's actually giving the treatment.

Q: So you think that talking alone isn't enough to actually make a change to your physical symptoms?

A: (participant shakes her head) That would make them all miracle workers, wouldn't it? (Patient, XC, line 348)

Q: You know you sound quite positive about your doctor. If you had maybe 50 minutes with her... [would that help]?

A: But she doesn't do, in normal medicine they don't do anything, except drugs. It's drugs. (Patient, XM, line 348)

So patients in this study believed that time spent in conversation alone did not lead to improvements in their symptoms; the therapeutic interventions did. Nonetheless, there is some validity in the views quoted previously. The oft-cited phrase, "I've got a lot of time for X", clearly demonstrates that within our culture giving time is associated with

apportioning value. Furthermore, some doctors openly acknowledge and respect the power of time and appreciation in promoting healing.

But I think that if an individual is treated as an individual, then I think they are well on the way to getting better. You know I think there is sort of a barrier with particularly looking at a screen and here's a prescription. I think that that is less likely to help. And complementary therapies tend to give a little more time. They feel a little bit more valued. (Doctor, WW, line 170)

Moreover, with increased time, listening is facilitated, which some study participants believed is an essential component of healing.

They know you've really listened and heard what they're saying, then they can start to deal with it in whichever way they want.... (Therapist, TH, line 144)

Conversely, this same therapist, who also had a nursing background, perceived the lack of listening by some mainstream practitioners as detrimental.

Because I had the time, I had the time to listen... when you go to see the doctor and he gives you a pill basically he's saying, "Here take this tablet and go away". (Therapist, TH, line 320)

In addition to listening, silence may also be important, which is increasingly acknowledged within the allopathic field as reflected in the quote below.

Inner silence has profound effects on both the body and mind. One experiences a state of deep rest, marked by decreases in heartbeat rate, oxygen consumption, perspiration, muscle tension, blood pressure and levels of stress hormones. One also achieves a state of heightened mental clarity and emotional ease. Whereas stress saps vitality, silence restores it. Whereas stress lowers resistance to disease, silence raises it (Bloomfield, 1989).

Some therapists in this study noted that with longer consultations, the opportunity for quiet reflection increases.

Well I just think it's [silence] essential. Because we get so little of it, because society as a whole is yin deficient, and for women especially the demands are that the attention should always be outside of the self and with other people. (Therapist, LK, line 191)

This same therapist continued by explaining her understanding of the connection between silence and healing.

Well it's when the babble in the mind can be stilled... it's as if you're in a café there's babble going on all around you but with babble going on all around you you're still turning attention to your own table and your own meal, the babble will still be there. But

when all the attention is on the babble there's no hope of opening up, there needs to be a certain amount of stillness and a certain amount of concentration before insight can arise, that's what I think, it's the insight that makes the change, it's the attention and consciousness going to the place where it has been stuck, it's the first place where people go because that's where it hurts. And you need to provide space for that to happen. The needles help to focus that. (Therapist, LK, line 191)

Patients also acknowledged that the needles worked to focus on pain and facilitate connections between current and past concerns.

I don't know how this can possibly work, but I do believe the acupuncture does actually trigger memories somehow. I don't know how that can work. But I was quite taken aback by myself. Really, that I suddenly started talking about you know things that I hadn't thought about in ages, but also opening up about current problems. (Patient, XM, 143)

Interestingly, all of the quotes from interview participants, whether biomedical or complementary, refer to the same phenomenon occurring in complementary therapy consultations: the application of focused attention. This attention may come from a therapist listening and/or by the client focusing inwards to pay heed to “where it hurts”. Some may dismiss and minimise the importance of this but therapists, and some of the doctors, believed it was critical for healing to occur. However, focused attention may not be the only healing element as patients believed the interventions themselves have a therapeutic value.

So, the concern is that in transferring complementary therapy consultations from the private to state funded sector, treatment time may be reduced, focused attention compromised, therapeutic interventions weakened and effectiveness impaired. In this study, this was expressed as a concern about “cutting corners”, a phenomenon that both patients and therapists mentioned.

You kind of feel that's the NHS, isn't it? They're always giving you the cheapest option even though you know it's brilliant that they did offer it [complementary therapy treatments] for five pounds and they cut corners a little and maybe that extra ten minutes can make a difference to somebody. (Patient, S, line 66)

I cut corners, which I shouldn't do. My history taking is slightly different. Whereas at [private clinic] I will allow the patient to tell their tale completely, here I let them start off but when I'm looking at the clock and it's ten minutes to go, I start cutting corners, trying

*to form another remedy, which is not the right way to do things.
(Therapist, TT, line 276)*

But although time may impact on clinical practice by disturbing and limiting the focused attention of therapists, patients may not notice the difference.

Q: In terms of time, the [NHS] sessions are about 50 minutes and her home sessions are in theory an hour.... So that's a difference of between ten and twenty minutes, do you have a sense of what's different in that ten to twenty minutes?

A: No, not really because it's all just so relaxing. The time just goes, you don't know. You've got no feeling of time because you're just in a situation where it is really, really relaxing. And time's got no length. (Patient, A, line 35)

Another patient also identified the level of relaxation as key to the quality of a consultation.

Q: What for you is the right amount of time in terms of an acupuncture appointment?

A: Well, the hour that we normally have.

Q: At [GP surgery] you only get 50 minutes don't you, 45 or 50 minutes?

A: What at [GP surgery]?....

Q: In theory it's supposed to be 50 minutes.

A: Ah, because it did feel like an hour.

Q: But when I saw you yesterday [at GP surgery] it was 46 [minutes].

A: Was it really?

Q: Yes and when I saw you at [private clinic] it was 49 [minutes].

A: Really?

Q: So they were actually

A: The same time

Q: More or less the same time, but did it feel that way to you?

A: I felt as though I'd had an hour yesterday [at the GP surgery].

Q: And what do you think gave you that sensation that felt like an hour?

A: I suppose the level of relaxation that you achieve. (Patient, XC, line 168)

This illustrates several interesting points. The first is that despite numerous previous appointments, the patient believes NHS consultations are 60 minutes. The second is that regardless of nearly equal consultation lengths, she felt that one was longer than the other. Finally, she equates the length of consultation time to the level of relaxation achieved. So, in considering the impact of reduced consultation time, as long as sufficient time is allowed to reach an acceptable standard of treatment and for patients to realise their expectations, then from the patient perspective, the actual consultation time may be shortened without repercussions. However, this study can only explore the process, not outcomes, of treatment. We do not know if shortened consultation times have an impact on therapeutic effectiveness and therefore health status.

To continue my exploration of the influence of time on clinical practice, I analysed observations of acupuncture consultations in each setting (private home, private clinic and NHS). The aim was to learn more about how time in consultations of different lengths is allocated to different activities. In particular, I was curious to learn what happens to the extra time. This type of comparison was not possible for the homeopathy consultations as appointment times in the two settings remained constant. However, with acupuncture consultations, several aspects were compared including:

1. Intended versus actual consultation length
2. Period of time that the patient lay with needles inserted (measured from the application of the first needle until extraction of all needles), also known as “needling time”
3. Number of procedures
4. Length and number of healing silences, defined as two minutes or more after all needles were inserted when both the therapist and patient remained silent

Please see Appendix I.

With the caveat that only two private clinic and three private home consultations were observed, these tables suggest some differences in the use and allocation of time in different settings. These include the following:

- The acupuncturist tended to run late in private consultations. Private home appointments overran by a minimum of two and a maximum of 12 minutes with an average of nearly eight minutes. Private clinic treatments also ran late but not by such a large margin (mean 2:44 minutes). But in the NHS setting, while the

therapist overran in four of the nine consultations, the remaining treatments finished within the fifty minute allocation.

- Because private home consultations overran to such an extent, on average private home client appointments were 20 minutes longer (mean 67:52 minutes ranging from 62:33 to 72:00) than NHS patients (mean 47:45 minutes ranging from 41:48 to 55:03) or private clinic clients (mean 47:44 minutes ranging from 46:27 to 49:00).
- Although intended NHS consultation time was 50 minutes and intended private clinic time was 45 minutes, in practice, on average, the length of consultation time was identical (47:45 and 47:44 minutes respectively).
- Needling time was twice as long for private home clients (mean 49:23 minutes ranging from 46:07 to 55:02) as for private clinic (mean 25:42 minutes ranging from 25:11 to 25:40) or NHS patients (mean 28:25 minutes ranging from 17:03 to 41:35). Interestingly, private clinic clients, on average, received the least amount of needling time, although only two consultations were observed.
- On average, private home clients received a greater number of procedures (2.3) than private clinic clients (1.5) or NHS patients (1.4).
- Private home clients experienced more healing silences for longer duration (on average 5.6 silences lasting on average 29:12 minutes) than NHS patients (on average 1.7 silences lasting 11:50 minutes) or private clinic clients (on average 1 silence lasting 3:21).

So in the case of this acupuncturist, extra time from extended consultations resulted in more procedures as well as longer needling times and healing silences. But there is much debate within the acupuncture community as to the therapeutic benefits of longer needling times (Campbell, 1999). The effect of this and the other noted differences, including longer consultation times, on health status is not known. But if we assume that the benefits from acupuncture consultations are derived from some combination of these elements, then this suggests that private home clients may have access to greater potential benefits. Given this, interestingly, NHS treatments, in terms of consultation time, needling time and number of procedures, were comparable to private clinic treatments. Only in healing silence is there a difference and that perhaps owed more to client specific factors (see Appendix I).

In summary, variations in consultation times can affect elements of the treatments, but patients and therapists might be unaware of these. The quality and perceived effectiveness of a treatment for both parties may be measured by other factors, such as the degree of relaxation. As long as consultation times remain of reasonable length, both patients and therapists are likely to be satisfied.

6.7 Summary

6.7.1 Main findings

This chapter opened with the theme of ‘patient characteristics’, finding that few differences existed between NHS and private patients. The next theme explored ‘similarities in private and NHS settings’ of which there were many – to the extent that it would be difficult to identify the setting location without prior knowledge.

The chapter continued by discussing ‘differences in private and NHS settings’ from the perspectives of therapists, patients and myself as the researcher, all of which were relatively minor. Within the next theme, ‘differences expected between private and NHS settings but not found’, I discovered that higher fees did not appear to influence the delivery or experience of complementary therapy treatments unduly. This chapter concluded by elaborating on a theme concerning the two most frequently noted differences, ‘space and time’. I found that differences concerning ‘space’ for patients centred on location of clinic premises, while for therapists there was an added dimension of acknowledgement of value to mainstream colleagues. With ‘time’, I found intended and actual consultation rates were remarkably consistent across homeopathy consultations regardless of setting, while there was greater variation in acupuncture consultations. NHS and private clinic acupuncture consultation times were comparable, but longer private home consultations meant that extra time was allotted to ‘healing silences’ and length of time with needles inserted.

6.7.2 Comparison of themes with existing literature

All of the themes in this chapter have been identified previously in Hills’s study of Glastonbury Health Centre (Hills, 2005). The theme of differences between private and

NHS settings was also explored in Christine Barry's ethnographic study of homeopathy in South London (Barry, 2003).

In comparing findings from this study with other studies, Strong (2001) and Silverman (1987) explored differences in private and state funded biomedical consultations through observation of consultations of hospital consultants. In both these studies, a principal finding was that the social relationship between the doctor and patient changed, with doctors behaving more impersonally within the NHS and relying on "collegial" authority, or the authority of the institution rather than the individual practitioner. Although I looked for these types of differences amongst the therapists I was observing, I could find little surface evidence that their behaviour varied in this way. Perhaps this could be explored more extensively within another analytical framework, such as conversation analysis.

In comparing these findings to studies of private and NHS complementary therapy consultations, I found some overlap. In her study of a professional homeopath and a medical homeopath, Barry found that the medical homeopath was always late, tired, hurried and "jaded" because of the pressures of time in the NHS setting (Barry, 2003). Although I would not describe either of the two therapists in this study in this way, within NHS consultations, the pressures of time were much more obvious. Moreover, in her interview study of professional therapists working in both NHS and private settings, Hills's participants identified many of the same differences as the therapists interviewed in my study, including variations in patient understandings of complementary therapies, complexity and longevity of patient conditions, premises, time, clinical autonomy and treatment delivery (Hills, 2005). Interestingly, however, because so many variations were discussed in interviews within both Hills's study and my own, I anticipated finding many more marked differences between the NHS and private settings when conducting observations of consultations. This was not the case. This leads me to two conjectures. The first is that, as Silverman suggests, because the study focus was on differences, these may have been over-emphasised at the expense of identifying similarities in interviews. The second is that therapists may internally be aware of differences, and believe they are externalised, but their behaviour does not reflect this. In fact at the second site, the observed therapist remarked that I would observe her difficulties with poorer boundaries with one of her private clients. Yet

when I observed this consultation and analysed it later, I could find little difference from those consultations in which the therapist felt the boundaries were clearer.

However, because only two therapists have been studied in a limited number of consultations, the transferability of findings from this study is limited. Other therapists working in complementary therapy services with more rigid protocols might find their clinical practice more severely affected. Indeed, two interview studies with therapists working in other NHS settings with stricter referral criteria and time restrictions found the therapists perceived that their practice was more radically impinged upon (Gibson, 2003; Hills, 2005).

Furthermore, the limited degree of variation found in this study may be due to the fringe status of complementary therapies within the NHS. As long as complementary therapy services are not 'core business', and this was the situation at both case sites, then perhaps an attitude of *laissez faire* predominates within the NHS system. If complementary therapy services were taken more seriously however, they might have to meet expectations of higher throughput, tighter time constraints and greater monitoring to mould them in line with NHS biomedical consultations. This point is expanded in the next chapter.

6.8 Conclusion

In exploring the micro topic of clinical practice, in this study I found few differences between consultations in private and NHS settings and those that were identified tended to be related to time and space. Therefore, there does not appear to be evidence here that the clinical practice of therapists in this study is much altered by the NHS setting. So, in considering the broader thesis question of the alterations necessary for mainstreaming complementary therapies, this suggests that some therapists would be required to make few changes to their clinical practice. The next chapter draws together the findings from the macro, meso and micro levels and discusses their implications.

CHAPTER 7 Discussion

7.1 Introduction

The aim of this study was to explore the mainstreaming of complementary therapies into NHS primary care. The main research question was: what adaptations are necessary amongst the complementary therapy community to obtain mainstreamed status within NHS primary care? To address this, I considered issues at macro, meso and micro levels. At the macro level, I explored the role of evidence. At the meso level, I looked at service design and delivery, in particular the structural and process features of a 'NHS acceptable' complementary therapy service. At the micro level, I investigated variations in clinical practice in private and NHS settings.

The purpose of this chapter is to draw together findings from across the three levels and discuss their implications. This chapter begins by discussing the themes from each of the macro, meso and micro levels. I then summarise the key contradictions and challenges that face proponents of mainstreaming. The chapter concludes with the application of change management models to assess the feasibility and progress of the mainstreaming of complementary therapies.

7.2 Macro level - Evidence

The aim of the chapter on evidence was to explore its role in mainstreaming complementary therapy services. Five themes were identified and discussed including:

- paradigmatic tensions between biomedical and complementary therapy models of health and illness
- rhetoric on evidence based decision making
- 'reality' of evidence available
- discrepancies between rhetoric and reality
- other influences on decision making.

7.2.1 Summary of themes at macro level

While exploring the theme of 'paradigmatic tensions', I found that some ask 'does it work?' while others focus on 'is there a benefit?' Depending on personal orientation,

different types of evidence are convincing. For example, evaluations tended to reinforce the beliefs of the converted without convincing sceptics, despite the production of positive health outcome data. But evaluations would be more valued, if they provided information on the impact of the service on NHS costs. However, the inclusion of these data, even with outcomes demonstrating a positive effect, may not influence the decision-making process. Hence, complementary therapy service providers must be seen to carry out evaluations, because these are expected markers of professionalism, cognisant that the results may make little difference on attitudes or decision making.

In looking at the theme of 'rhetoric on evidence based decision making', the discourse at national and local levels suggested that "strong" clinical evidence was the gatekeeper to mainstream status. But several difficulties and incongruities were identified in this study, while exploring the theme of 'discrepancies between rhetoric and reality' including:

- The assumption was erroneously made that claims of "strong" evidence were free from personal interpretation. However (unsurprisingly), there was no consensus on which therapies had "strong" evidence.
- The majority of commissioners and clinicians did not know the evidence on complementary therapies firsthand, nor did they know where to find it as studies in complementary therapies were rarely published in their favoured mainstream sources. Therefore, opinions about therapies with "strong" clinical evidence were usually based on unconfirmed impressions.
- The complementary therapy with the strongest evidence base (herbal medicine) in the literature was the least prevalent of the "Big 5" in general practice and was actively excluded at one site, while other less evidence based therapies were adopted.
- Counselling, a therapy that was formerly outside the NHS, now is widely provided within the confines of the NHS, although the evidence for counselling is weaker than for some complementary therapy interventions.

- Doctors at site one who professed that clinical evidence dictated their decision-making referred patients to complementary therapies, despite stating that the evidence for complementary therapies was negligible.
- In the commissioning bid for the re-vamped complementary therapy service submitted at the first site in 2006, no supporting information on clinical evidence appeared nor was any required.

Perhaps these discrepancies between the rhetoric and behaviour of NHS professionals is due in part because professionals' views can be shaped by forces other than clinical evidence such as patients' experiences, the perceptions of experts, personal contact with researchers, the views of trusted colleagues and their interactions with each other, as found with the theme of 'other influences on decision making'. If this is true and, to take Gabbay and Le May's (2004) terminology, "mindlines" are influential in shaping professionals' beliefs, then proponents of the mainstreaming of complementary therapies need to devise strategies to reach and influence both high ranking and grassroots professionals' informal networks and their "knowledge in practice". In essence, they need to become political..

7.2.2 Being 'political'

In her study of the professionalisation of osteopathy, homeopathy, chiropractic, acupuncture and herbal medicine, Dixon gives excellent examples of just how complementary therapists have acted 'politically' at policy level in the past (Dixon, 2007). For instance, the statutory regulation of osteopathy in 1993 was largely due to political activity on the part of Simon Fielding and of key people across several institutions.

In Dixon's account, Simon Fielding, an osteopath, met Nigel Clarke, who had worked for the former Home Secretary William Whitelaw in the mid 1980's. From Clarke, Fielding learnt about the process of getting a bill through Parliament. Clarke suggested that Fielding contact Robert Maxwell at the King's Fund, which he did "out of the blue". Robert Maxwell provided two important contacts.

The first was HRH the Prince of Wales, who hosted a lunch at Kensington Palace and invited the head of the General Medical Council, health ministers, Presidents of the Royal Colleges and Fielding in 1988. This event was largely credited with decreasing

medical antipathy towards statutory regulation of osteopaths. The second contact provided by Maxwell was Tom Bingham, a future Lord Chief Justice, who was Maxwell's friend from "Oxford days". Tom Bingham agreed to chair the King's Fund Working Party on Osteopathy. The Working Party proposed the Osteopath's Bill, which was put forward in Parliament by Lord Walton of Detchant, another King's Fund friend and past president of the British Medical Association and the General Medical Council. At the second reading of the Bill, explicit support was offered by Tom Sackville, then Parliamentary Under Secretary for Health and the son of a past President of the General Council and Register of Osteopaths. The Bill passed in May 1993.

As Dixon says, this policy change came about because

...of people with personal connections, rather than formal affiliations.... The association of a high profile and well respected lawyer and a former President of the BMA and GMC, together with sponsorship by the King's Fund, gave legitimacy to the osteopaths' bid for statutory regulation. Perhaps crucial was the personal interest of HRH the Prince of Wales (Brown, 2004) who himself confessed that he "took a particularly close interest" in the statutory regulation of osteopaths and chiropractors (Prince of Wales, 1997) (Dixon, 2007).

This is an excellent example of networking, lobbying and tapping into 'friends in high places' that characterises political manoeuvring. It also epitomises 'perfect timing', where the confluence of the right people in the right places at the right time are catalysed by 'policy entrepreneurs' such as Simon Fielding.

- Currently, however, the picture is less optimistic. The right people are scarce. Gordon Brown, who was policy advisor on complementary therapies at the Department of Health, retired in 2004 and has not been replaced. Several of the actors named in the account above have also retired. The Prince of Wales has been muzzled by recent accusations of unconstitutional meddling in politics. Furthermore, there appears to be a dearth of 'policy entrepreneurs' like Simon Fielding, who have the leadership abilities and the confidence to make the connections to bring about policy changes. Hence, the elements for successful high level politicking are currently absent or disabled.

However, this is not to say that mainstreaming proponents currently engage in no political activity whatsoever. The Foundation for Integrated Health launched the

Integrated Health Associates programme in November 2006 with the aim of establishing a network of likeminded biomedical and complementary therapy professionals (osteopaths and chiropractors only) at grassroots level. The ICAM Unit at the University of Westminster and the Alternative and Complementary Health Research Network (ACHRN) organise national meetings for academics to discuss (and sometimes respond to) NHS policies and politics. The British Holistic Medical Association has organised local development groups with the aim of bringing in more “holistic” care (personal communication, William House). MPs such as David Treddick (personal communication, Jane Wilkinson) and Peter Hain (Hain, 2004) have spoken out in favour of provision of complementary therapies. But on the whole, these efforts are isolated incidents that appear to have limited impact rather than a co-ordinated campaign involving a range of political allies.

Likewise at local level, there are occasional instances of successful deployment of political strategies (for example the reprieve of the service in case site one in 2006), but again these tend to be one-off occurrences when the funding of particular services is threatened (e.g. GetWell UK, Impact, Glastonbury Health Centre), rather than a unified campaign. Instead of developing successful political strategies at national and local levels, mainstreaming proponents appear to be relying on research and, to an extent, regulation. To genuinely move the mainstreaming agenda forward, emphasis on political activity at national and local levels needs to be greater.

7.2.3 The call for evidence as a ‘red herring’

In the meantime, what function does the rhetoric on clinical evidence serve? Even Professor Edzard Ernst, long noted for calling for further evidence, has been puzzled by the “curious contradiction” of the inclusion of some therapies into national guidelines, while other interventions with similarly good evidence are excluded (Ernst *et al.* 2007).

I believe the rhetoric on clinical evidence fulfils two purposes. The first is that it provides a ‘red herring’. By ‘red herring’, I mean that instead of putting commensurate effort into political activities that would significantly advance mainstreaming, proponents are distracted by demands for research on therapeutic effectiveness. I would argue that the call for regulation is a similar ‘red herring’, since osteopaths and

chiropractors have been statutorily regulated since 1993 and 1994 respectively, yet are still not fully mainstreamed. Like regulation, the further generation of randomised controlled trials (RCTs) consumes considerable amounts of time, energy and money. These studies are carried out under the pretext that more RCTs will provide conclusive ‘proof’. This keeps people busy. In fact, if funding were available, it would occupy researchers for decades, as theoretically, each complementary therapy intervention would need to be tested in every potential condition. So, for example, trials have shown that acupuncture is effective for headaches, but anecdotally so are osteopathy, chiropractic, homeopathy, reflexology, massage and many other therapies. All of these would need to be trialled, and trialled repeatedly, before assuming mainstreaming status. Technically speaking, because of the great variation of techniques within therapeutic modalities, individual interventions should also be trialled. So, acupuncture, needling, cupping and moxibustion should all be tested individually and in various combinations to identify precisely what “works” for each specific condition. But, as is the case with acupuncture and headaches, even if interventions are found therapeutically and cost effective in good quality trials, the intervention is likely to still be excluded from the NHS. As Broom and Tovey concluded in their study of the integration of complementary therapies in two cancer units,

The system, as outlined by a number of the specialists interviewed here, can be flexible if the desire to be flexible exists, but there exists a default position if management do not view treatments as appropriate. This position is that, in cases where any doubt exists regarding the logic behind the treatment (i.e. its paradigmatic base), it must reach the so-called gold standard. This may pose significant difficulties when treatments are perceived to be paradigmatically incommensurable with the biomedical model; a model which clearly underpins the informal system (Broom and Tovey, 2007).

7.2.4 The call for evidence as a rationing device

This brings us to a second role of clinical evidence in mainstreaming complementary therapies – to impede access to the NHS. The first report on rationing, or priority setting in the NHS, was published by the government in 1976 (Mendich, 2005). For the past fifteen years clinical evidence, with systematic reviews of randomised controlled trials set as the gold standard, have increasingly become a tool to help set those

priorities, especially with the establishment of the National Institute for Health and Clinical Effectiveness (NICE). For many, the furthering of the symbiotic relationship between evidence based medicine and evidence based policy making is entirely appropriate; only those interventions which are “proven” by research evidence should be offered in the NHS (Donald, 2001; Cookson, 2005). Others suggest that this approach overly prioritises the claims of scientific researchers and cost, patient preference, feasibility and the previous experience of policy makers and clinicians should also be factored in (Klein, 2000; Black, 2001; Raine, 2005). Other concerns are that research is employed when there is a consensus amongst decision makers and used selectively when there is not (Black, 2001) and research legitimates decisions that have already been made (Klein, 2000). Harsher critics have suggested that evidence based policy making favours the pharmaceutical industry (Druss, 2005) and that far from being “objective”, evidence based medicine obscures inherent subjectivity, by purporting that decisions are made in a social context vacuum (Goldenberg, 2006).

Within the complementary medicine research field, some argue that evidence based policy making is beneficial to the mainstreaming agenda in setting a common yardstick for both biomedical and complementary therapy interventions (Vickers, 2001). But others warn that the demand for clinical evidence will lead to the control of complementary therapies to neutralise their threat to biomedicine (Barry, 2006). Put more colourfully, the rise of evidence based medicine is:

A stick with which to beat CAM, thus providing a new tool for orthodoxy in the ongoing historical struggle to undermine and marginalise CAM at one level while at another selectively co-opting and incorporating aspects of CAM treatment into orthodox practice (Willis and White, 2004).

So, observers from both the complementary medicine and biomedical fields have commented that “evidence” is used to decide who and what is in (or out). It is not within the scope of this study to chart or critique the evidence based movement in depth, but it appears that the development of evidence based decision-making has arisen partly as a response to increasing healthcare costs (Walker, 2003; Steinberg and Luce, 2005). This leaves commissioners and policy makers with the concern voiced by several of the study participants: Can the NHS actually afford complementary therapies?

Thus, in summary, I think that the purpose of the call for clinical evidence is to ration access to a cash strapped NHS and provide a time consuming ‘red herring’ in the bargain. Put baldly, many mainstreaming proponents have unwisely bought into the rhetoric of local and national NHS policy makers. That said, I am not arguing that clinical evidence has no effect. Despite my cynicism, there is some suggestion in this study that research may have had some influence on some NHS professionals’ attitudes. For example, some study participants believed that the evidence for acupuncture was improving – at a time when it was. However, as demonstrated earlier, a change in attitudes does not necessarily lead to altered behaviour. Thus, it would be imprudent to depend on research to slowly change attitudes that might (or might not) lead to alterations in behaviour that may (or may not) advance the mainstreaming agenda. Excessive reliance on research to promote the mainstreaming agenda is misguided. However, as the right elements to bring about mainstreaming are currently in short supply (i.e. ‘policy entrepreneurs’, ‘friends in high places’) and the present climate is so unfavourable, perhaps the generation of further research is an understandable stopgap.

7.3 Meso level - Service design and delivery

The aim of the meso chapter was to identify the features of a ‘NHS acceptable’ complementary therapy service. Four broad themes (with several sub-themes) were developed including:

- Description and history of development of services at case sites
- Structural factors influencing service design, delivery and survival
- Factors that did not influence service design, delivery or survival
- Process factors influencing service design, delivery or survival

7.3.1 Implications of ‘process factors’ theme

In exploring the theme of ‘process factors influencing service design, delivery and survival’, I identified three key elements in this study: 1) the presence of a “champion” with clinical and commissioning roles, 2) collegial regard and relationships, and 3) shared patient-centred care philosophy and approach. Each is discussed in turn below.

In order to establish and maintain complementary therapy service provision in the NHS, a clinician, ideally a doctor, with both clinical and commissioning responsibilities and roles was crucial. As WW, a doctor from site 2, said such individuals are essential to “fly the flag” and “stick their neck out”, especially when services are under threat. An interview study with commissioners from 1999-2001 also found that the presence of GP “champions” was a key driver (Thomas *et al.* 2004).

Deploying respected clinicians to market and spread the use of services or interventions is not new. In their evaluation of the PACE programme [Promoting Action on Clinical Effectiveness (Dunning *et al.* 1999)], researchers found that “opinion leaders” (also known as “champions”) along with strong evidence and a committed organisation were the three factors of successful implementation of biomedical innovations (Dopson *et al.* 2001). Similarly, Eve and colleagues of the FACTS programme (Framework for Appropriate Care Throughout Sheffield) also advocated use of champions to spread evidence based practice, but warned that this strategy on its own would not create the desired change (Eve *et al.* 1996). In evaluating 17 implementation projects in North Thames Region, we did not find that opinion leaders were essential, but that good clinical leadership of the change process was (Wye and McClenahan, 2001).

However, since the implementation of practice based commissioning in early 2007, the role of the champion has become even more complex. Practice based commissioning has multiplied the numbers of gatekeepers, increasing the likelihood of objections to complementary therapy service provision. Hence, the “flag flyer” ideally needs to adopt multiple roles within a local surgery, the consortia and the PCT. Few individuals can satisfy such wide-ranging criteria and manage these demanding roles, without becoming sorely overstretched.

The second process element identified in my study was collegial status, or being “under the same umbrella”. Perhaps this was inherently more possible at the second site, as two of the three therapists, a nurse and a doctor, were biomedical professionals previously known to the women’s health team. As individuals and colleagues they were already familiar, only the treatments provided were ‘strange’. To reduce this unfamiliarity, mutual observation of consultations were crucial. Through this mechanism, the doctors at the second site gained “an understanding of actually how

the homeopath works”. (Doctor TL) As a result, homeopathy referrals were higher than those for reflexology/ aromatherapy, where observation of consultations did not occur. In addition, doctors came to respect homeopaths as professionals in their own right, not as dubious charlatans.

But there are two obstacles to observation of complementary therapy consultations. The first is that many clinicians may not be willing to spend the time. To counter this reluctance, perhaps complementary therapists could initiate the process by requesting permission to observe biomedical consultations. If granted, this might be an opportunity to build inter-professional relationships, ultimately with the goal of the acceptance of a reciprocal invitation. The second obstacle is that many therapists are reluctant to permit their consultations to be observed, citing the intimacy and confidentiality of the consultation. A likely prerequisite for mainstreaming to occur is the opening of complementary therapy consultations to outsiders.

A shared healthcare philosophy, in this case patient-centred care, was the third process element of a ‘NHS acceptable’ complementary therapy service identified in this study. But what is patient centred care? Stewart claims that patient-centred care, as defined by patients:

- Explores the patients' main reason for the visit, concerns, and need for information
- Seeks an integrated understanding of the patients' world that is, their whole person, emotional needs, and life issues
- Finds common ground on what the problem is and mutually agrees on management
- Enhances prevention and health promotion
- Enhances the continuing relationship between the patient and the doctor (sic) (Stewart, 2001).

If we accept that definition, then the complementary therapy consultations I observed certainly fell into that category and so, by report, did the consultations offered by the doctors at the women’s health service. Because the doctors and complementary therapists adopted similar values and consultative approaches, only their therapeutic tools were different. They already shared important commonalities.

7.3.2 Implications of ‘structural factors’ theme

In developing the theme of ‘structural factors influencing service design, delivery and survival, I found that a model NHS complementary therapy service would:

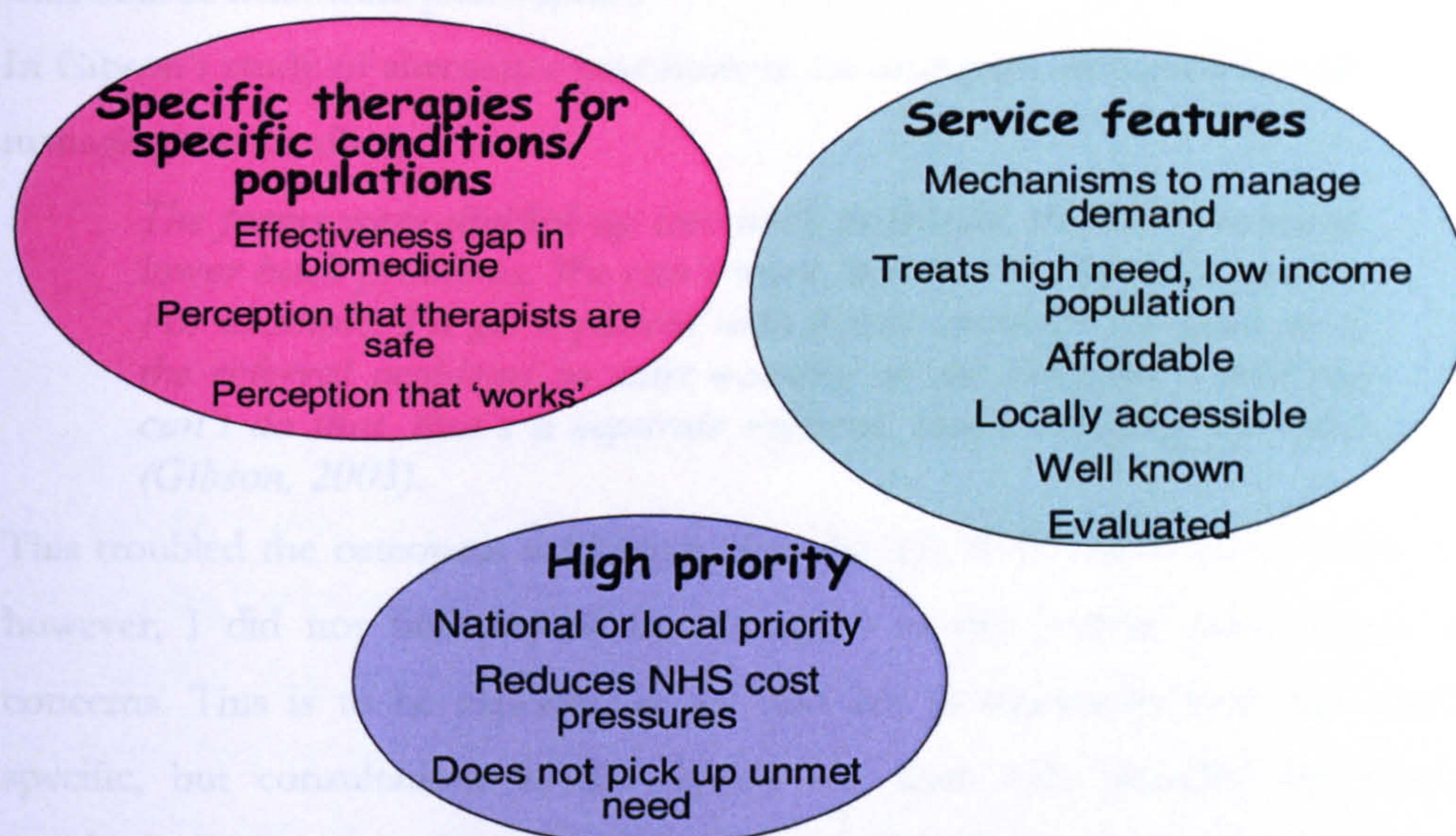
- Target specific conditions where current biomedical treatments are limited, ineffective or non-existent, with a small number of specific therapies. Therapies/ interventions would be chosen on the basis of the belief that they are as effective (or more so) as current interventions, a belief fostered through perceptions of “good” clinical evidence, anecdotal accounts and/ or a mechanism of action that makes scientific sense.
- Target populations with high health needs that are unable to afford private complementary therapy treatments and have conditions of high national and/or local priority.
- Target the needs of those already in the health system more efficiently and effectively without picking up the needs of those currently outside NHS service scope.

In addition, the service would:

- Provide treatments by “safe” therapists.
- Incorporate mechanisms to regulate demand such as limitations on total number of sessions, and gatekeepers who control access.
- Be accessible (ideally in-house) and affordable (ideally at no cost to the patient).
- Be made known through a variety of measures, including opportunistic, informal encounters with NHS staff.
- Be regularly evaluated, including data collection on the impact of the service on prescription, consultation and secondary care referral rates.

To represent this pictorially, please see the figure below.

Figure 6 Structural features of a 'NHS acceptable' complementary therapy service



But there are several difficulties inherent within the structure of a 'NHS acceptable' model. First, there is an issue with 'mechanisms to regulate demand'. Once both case site services were NHS funded, mainstream clinicians became gatekeepers to the complementary therapy service. In the second site, there was universal approval as the doctors had observed homeopathy consultations and were sufficiently knowledgeable to inform patients. But at the first, clinicians professed little knowledge of the therapies and, in some cases, even less interest. Yet despite this, clinicians still were lodged in these responsible roles. This gives NHS clinicians an unearned, and possibly, an unwanted power. As Gibson argues,

If GPs are to be the gatekeepers then there is no room for alternative practitioners to achieve professional equity (Gibson, 2003).

Secondly, a 'NHS acceptable' model seriously challenges the holistic tenet common to so many complementary therapies. Working "holistically" means attempting to balance individuals in their inter-related emotional, mental, physical and spiritual complexity rather than focusing on alleviating a narrow set of predominantly physical (and occasionally mental) symptoms. In doing so, therapists see themselves as generalists. But the model, with specific treatments for specific conditions, treats therapists as

specialists, for example acupuncture is “good for” pain. So how can therapies be both holistic and selective? Targeting treatments for specific conditions essentially conflicts with holistic healthcare philosophies.

In Gibson’s study of alternative practitioners, an osteopath recounted her difficulties in managing this conflict.

The forms were divided up into neck problems, thoracic problems, lower back problems. We can’t work like that, it’s not osteopathic. For example, I’d get a patient with frozen shoulder [in addition to the referral problem] so start working on the shoulder – well you can’t do that, that’s a separate referral, that’s breaking the rules (Gibson, 2003).

This troubled the osteopath sufficiently that she left NHS employment. Interestingly, however, I did not find any of the therapists in this current study voiced those concerns. This is to be expected at the first site as treatments were not condition specific, but consultations at the second site were only intended for hormonal problems. Difficulty had arisen around this in 2003-2004, when the waiting list had grown extensively and consequently the homeopaths were asked to “only treat hormonal conditions”. However, homeopaths did not appear to change their behaviour, instead the doctors largely managed the problem by decreasing referrals until the waiting list dropped to acceptable levels. Nonetheless, in services where criteria are more strictly enforced, as Gibson’s example above, there is a conflict between targeting specific conditions with holistic treatments.

Third, there is the issue of unmet need. To recap, unmet need is defined as:

- Those suffering potentially dangerous conditions without knowing it
- Those aware of their condition but not seeking treatment either because they were managing it themselves or because they were ignoring their condition
- Those aware of their condition and seeking treatment but no services were available
- Those aware of their condition and seeking treatment, but available services were substandard or ineffective

For many therapists, those people who are self-managing their condition (definition 2) are just the type of clients for whom complementary therapies, with their emphasis on prevention and self-care offer the greatest benefit. Instead of playing to the strengths of

complementary therapies and offering these patients the extra resources they may require, a 'NHS acceptable' model does not encourage important self-management benefits and health behaviours, which ironically are exactly those currently being promoted in national initiatives, such as the Expert Patient programme (see www.dh.gov.uk) and policies (Department of Health, 2006b; Department of Health, 2007).

Furthermore, according to the model, the conditions treated should fill an effectiveness gap, defined as an area where current interventions are inadequate or non-existent (definitions 3 & 4). But the model also stipulates that only those patients already within the system should be treated, and treated more effectively. If current biomedical services are inadequate, patients may already be within the system, but if services are non-existent, they are likely to be outside the NHS. Likewise, those who are self-managing or unaware of their condition (definitions 1 and 2) are also outside the health system, but may be included once appropriate services are in place. Commissioners (such as PCT manager BC) are concerned that mainstreaming complementary therapies will extend the already over-stretched boundaries of the NHS, as have other community service initiatives. In brief, the boundaries of the NHS would encompass patients meeting all four definitions of unmet need.

So how can complementary therapy services be designed to plug effectiveness gaps while simultaneously only treating those already within the system? Providing more effective treatment for conditions currently not well treated will, by definition, create demand. This is obvious to everyone, including the pharmaceutical industry. In the Cooksey report on research funding, which was commissioned partly to review incentives to keep pharmaceutical companies within the UK, researchers are urged to identify and close "unmet needs" with medicines that open up new markets (Cooksey, 2006). This implies that addressing "unmet needs" may be acceptable, as long as they are met with a pharmaceutical agent.

Fourth, the model requires complementary therapy interventions to be cheaper than current biomedical interventions, more effective and reduce costs elsewhere in the NHS. How many biomedical treatments are likely to meet those stringent criteria? I believe that by operating double standards, setting excessively demanding goals and giving paradoxical challenges (ie meet effectiveness gaps without picking up unmet

need), the NHS is clearly indicating a deep-seated reluctance to incorporate complementary therapies.

7.4 Micro level - Clinical practice

The aim of the micro topic of clinical practice was to explore differences in clinical practice in private and NHS settings. The themes developed were:

- Patient characteristics
- Similarities in private and NHS settings
- Differences in private and NHS settings
- Differences expected in private and NHS settings but not found
- Space and time

7.4.1 Summary of themes at micro level

In exploring the theme of ‘patient characteristics’, I found that there was not much difference between those observed privately and in the NHS, which perhaps was to be expected in the acupuncture observations as I specifically requested access to patients who were treated in both settings. In summarising the themes of ‘similarities and differences in private and NHS settings’, I found that variations were minimal and mainly due to modifications of time and space. In particular, the questions asked by the homeopath were remarkably similar across settings and consultations, even for different conditions. With the theme of ‘space and time’, I found that the most important aspect of space for clients was convenience of location and for therapists was the level of noise. Therapists perceived the location of the consultation room within the building, as an indication of the value accorded their treatments. Quality of décor was not highly important to either therapists or patients. In relation to time, reductions in acupuncture consultation length led to a decrease in needling time and ‘healing silences’, but not in patient or therapist satisfaction or perceptions of effectiveness.

7.4.2 Implications of findings at micro level

In exploring the implications of these findings, I wish to draw out three points. The first concerns standardisation. Once the homeopath was employed in the NHS, she

consciously made a choice to regularise treatments across private and NHS settings to meet time restrictions of 60 and 30 minutes. But interestingly, only her set of questions was constant; client responses were still ad hoc and remedy choice was tailored according to her clinical judgment. Both the therapist and the (few) clients I interviewed appeared satisfied with this approach. This suggests that at this site some standardisation was introduced into homeopathy consultations, at least, without a detrimental loss of client specificity. Concerns about standardisation are more alarming with prescriptive guidelines on treatments, as one study participant phrased it

If someone has a bad back, you manipulate their 5th lumbar vertebrae on the right and that resolves X number of bad backs therefore you apply that to every bad back. (Key Informant, osteopath and healer, CG, line 31)

At the moment, this degree of standardisation of complementary therapy treatments seems farfetched. But with the advent of the “tick box” approach of the Quality and Outcomes Frameworks (QOF), it is common in biomedical consultations (Freeman, 2006; Jelley, 2006; McDonald *et al.* 2007; Mangin and Toop, 2007) and could become so within complementary therapy consultations, if they were mainstreamed.

The second point is that although acupuncture consultations were shortened in NHS settings to 50 minutes, patients and the therapist believed there was no impact on effectiveness. However, the medical homeopath, who had reduced her consultation times by 15 to 30 minutes, did believe therapeutic effectiveness was compromised. This suggests that there was a delicate balance between sufficient consultation length and the productivity demands of the NHS. Moreover, in my study, acceptable consultation lengths appeared to vary between therapies, and even therapists from the same discipline. Van Haselen and colleagues argue that it is imperative to identify appropriate consultation lengths and this will be “pivotal in ultimately determining the value for money for many complementary therapies” (van Haselen *et al.* 1999). The question this then leaves is: to what extent can complementary therapy consultation length be reduced, without compromising quality and endangering the mechanism of action? If individual consultations are too lengthy, would group consultations, as currently practised by the Gateway clinic (Joire, 2007) be a viable alternative?

The third concerns variation in how time is spent in biomedical and complementary therapy consultations. In exploring biomedical consultation times, average consultation

time for doctors has jumped from 6 - 7 minutes in the 1960's to 9.36 minutes in 1997 (Mechanic, 2001), an increase of around a third. Yet British doctors continue to lament the lack of time they have with patients (Freeman *et al.* 2002; Pollock and Grime, 2002). As there has been an appreciable increase, how have consultations changed? How do clinicians spend extra time in longer consultations?

In a systematic review of 14 studies, Wilson and Childs found that doctors who had longer consultations prescribed less and were more likely to proactively advise on lifestyle and prevention (Wilson and Childs, 2002). In comparing 210 videoed consultations of hypertension patients from 1986 and 2002, Bensing and colleagues found that more recent patients were less active, talked less and asked fewer questions. Instead, "task oriented" and "businesslike" GPs provided more medical information and asked fewer questions about the patients' conditions; these differences were attributed to the rise of evidence based medicine protocols (Bensing *et al.* 2006). A massive Dutch study of 2784 videoed general practice consultations from 1987 and 2001 also found that GPs asked fewer questions, demonstrated less empathy and sought less dialogue (Jones *et al.* 2004). So, doctors appear to be talking "at" patients, while patients sit mutely.

This could be due to the introduction of computers into the consultation room. A very early study in 1986 found that computers increased the percentage of "doctor speech" and decreased "patient speech", with corresponding increase in doctor administration and "doctor only activity time" (Pringle *et al.* 1986). A more recent study specifically exploring the impact of computers on 30 consultations found that physicians spent 25-42% of their time gazing at the screen and consequently the doctor initiated less psychosocial prompts and demonstrated less emotional responsiveness (Margalit *et al.* 2005). The Dutch study found that significant periods of silence of up to a minute occurred in many consultations while the computer was consulted for guidelines and electronic patient records (Jones *et al.* 2004).

Furthermore, patients do not have much opportunity to speak about psychosocial issues with nurses either. In comparing nurse consultations, which were longer than GP consultations, a study found that nurses spent more time giving instructions and engaging in administration than discussing emotional aspects of the patients' lives

(Seale *et al.* 2005). This suggests that even with longer consultations, the tendency within biomedical consultations is towards advice giving and administrative tasks.

So, contrary to policy directives, patients increasingly have a less active role in the consultation process, as a consequence of the introduction of computers and, some argue, evidence based medicine protocols. These changes originated from external demands within the system to monitor and influence the consultation process. Of course, a more passive role may suit some patients – not all seek out their GPs and practice nurses for in-depth psychosocial exchanges (Barry *et al.* 2001; Peltenburg *et al.* 2004). However, for those patients who do want to explore psychosocial agendas more thoroughly, and this may be increasingly widespread with the growth of health consumerism, there may be less flexibility within biomedical consultations. How does this compare with complementary therapy consultations?

In the consultations observed in this study, a broad range of topics were covered, ranging from physical ailments to significant relationships to spiritual beliefs, even in the acupuncture consultations where much less talk took place. Inquiry into psychosocial aspects comprised a major proportion of the conversations. Clients reported feeling “listened to” because their concerns were elicited and largely heard and acknowledged. Silence rarely occurred in the homeopathy consultations, and usually at the end, when the homeopath was preparing the remedy and the patient filled in a MYMOP questionnaire. But this was a common feature of the acupuncture consultations. Instead of silence being an artefact of administrative tasks, it was actively cultivated to assist in the healing process.

Instruction giving and lifestyle advice did occur with both homeopathy and acupuncture. The homeopath more frequently gave instructions, usually on how to take the remedy, while the acupuncturist provided more advice, mainly on diet and exercise. But these activities made up a small part of the consultation process. Laughter, tears and other signs of “emotional responsiveness” were frequent. During conversations, eye contact was relatively constant; therapists, especially the homeopath, occasionally looked away to take notes but then the gaze was returned to the client. Needless to say, computers were completely absent.

In comparing biomedical consultations, as depicted in the literature, and complementary therapy consultations, as observed in this study, the overwhelming

impression given is that biomedical consultations appear increasingly mechanised and busy, hence this might partly explain continued complaints from doctors about lack of time with patients. Although consultation times are longer, doctors are not spending more “quality time” with patients than previously, to the regret of both (Cape, 2002). In fact, in an interview study with hospital consultants who carried out both NHS and private work, Humphrey and Russell found that many doctors

...expressed their frustration at their limited role as literally ‘consultants’ in the NHS who have just fleeting contact with their patients and appreciated the opportunity in the private sector to get to know their patients personally and see them through a whole illness episode (Humphrey and Russell, 2004).

Meanwhile, complementary therapy consultations are almost exclusively focused on therapist-client interactions and are remarkable for the almost total absence of any external monitoring of the “cosy egg” (Therapist RR) of the consultation. No wonder client satisfaction with complementary therapy consultations is so great (Mitchell and Cormack, 1999b; Kelner, 2003a). The appeal is not just consultation length, but the way time is spent.

Of course, the counter argument is that the evidence is inconclusive on whether patient-centred care, as exemplified in this study by complementary therapy consultations, results in better outcomes (Howie *et al.* 2004). The introduction of evidence based protocols and computers may have a larger positive impact on health status. In the meantime, patients continue to seek out complementary therapy consultations.

7.5 Summary of contradictions and challenges

The previous sections have summarised and elaborated the themes of this study for the macro, meso and micro levels. In doing so, I have drawn out internal contradictions within the NHS and external contradictions between biomedicine and complementary therapies. In summary, principal contradictions include:

- Service evaluations are called for, but despite positive health outcome data they do not convince the sceptics. In addition, they may have little influence on the decision-making process, even when demonstrating a favourable impact on costs.

- The rhetoric at national and local levels suggests that the production of clinical evidence demonstrating therapeutic effectiveness is the key to mainstreamed status. But the referral behaviour of clinicians and funding decisions of PCT managers often belie this.
- A 'NHS acceptable' complementary therapy service targets a specific (physical or mental) illness *condition*, while complementary therapies focus on the *person*, treating physical, mental, emotional and spiritual conditions.
- A 'NHS acceptable' complementary therapy service features the inherent paradox in that it should target "effectiveness gaps" in biomedicine, while simultaneously avoiding picking up any unmet need. But, identifying and filling a gap necessarily implies satisfying unmet need.

In addition, this study has identified a number of challenges to attaining mainstream status. These are not impossible, but do make the widespread mainstreaming of complementary therapies more difficult. Challenges include:

- NHS complementary therapy services need to demonstrate better health outcomes than current interventions, for less cost and show an appreciable impact on NHS costs elsewhere.
- Clinical champions (ideally doctors in this study) with commissioning roles who are enthusiastic about complementary therapies and willing to advocate for the service are crucial - and rare.
- Inter-professional relationships between NHS professionals and complementary therapists are essential, but these are difficult to forge and cultivate when there is little crossover between the two camps.

So, this suggests that the furthering of the mainstreaming agenda can make little progress, because the criteria set by the NHS are inconsistent, paradoxical, unachievable and fundamentally in conflict with the philosophies and principles of complementary therapies. But despite this, I did find an example at the second site where these had been surmounted for eight years. However, in some ways this service did not meet the ideal of a 'NHS acceptable' complementary therapy service, for example women's hormonal problems were not a national or local priority. Nor were

the features and professional approach of its biomedical component (the women's health service) particularly commonplace. So, this leads me to two conclusions.

The first is that during times of abundance when coffers are buoyant, innovation is encouraged and patient centred care (as defined previously) is prioritised, complementary therapy services that meet NHS requirements 'well enough' may be allowed to infiltrate into the NHS. The second is that although this might occur on occasion, because the contradictions and challenges are so great, the widespread adoption of complementary therapy services provided by professional therapists within the current NHS is unfeasible. Ad hoc complementary therapy services might appear within mainstream services and operate in a "parallel" or "consultative" existence, as was the case in two case sites in this study, but the widespread diffusion of truly "integrative" services, in which there is an "interdisciplinary, non-hierarchical blending of both conventional medicine and complementary and alternative health care" (Boon *et al.* 2004a) is unlikely. The next section explores this further through the lens of change management.

7.6 Change management models

Having identified the range of changes necessary, the aim of the next section is to present and apply a series of change management models to further address the question: could complementary therapies be mainstreamed into NHS primary care? The movement of complementary therapies from outsider to insider status necessitates change: changes in culture, organisations, systems, behaviour and attitudes. Yet to my knowledge, although a wealth of change management models exist (Iles and Sutherland, 2001), only one attempt has been made to apply them to the mainstreaming of complementary therapies (Valente, 2003), and this focused on one model in relation to the uptake of complementary therapies amongst potential users. I believe that by applying a range of change management models more broadly, considerable insight can be gained into the levers to, obstacles to and feasibility of mainstreaming.

Undoubtedly, these models would be more adeptly employed if a variety of individuals from a range of perspectives considered them. But by necessity, only my own views have been included here. Moreover, in applying the models, I have drawn on multiple

sources of information including the themes from this study as well as wider literature. Because of this, the conclusions drawn may appear somewhat speculative.

The models below have been chosen because they shed light on the likelihood of and/or the current stage of progress in mainstreaming complementary therapies. Five models have been selected. The first three give insight into the question “Is the change feasible?” and explore the receptiveness of the current climate to the ‘innovation’ of the mainstreaming of complementary therapies and examine the suitability of the innovation itself. The latter two offer perspectives on “Where are we in the change process?” These are not necessarily the “best” models, in fact one is particularly out of favour at the moment. However, the aim of this section is not to critique the models, but to answer questions of feasibility and progress in relation to the thesis topic.

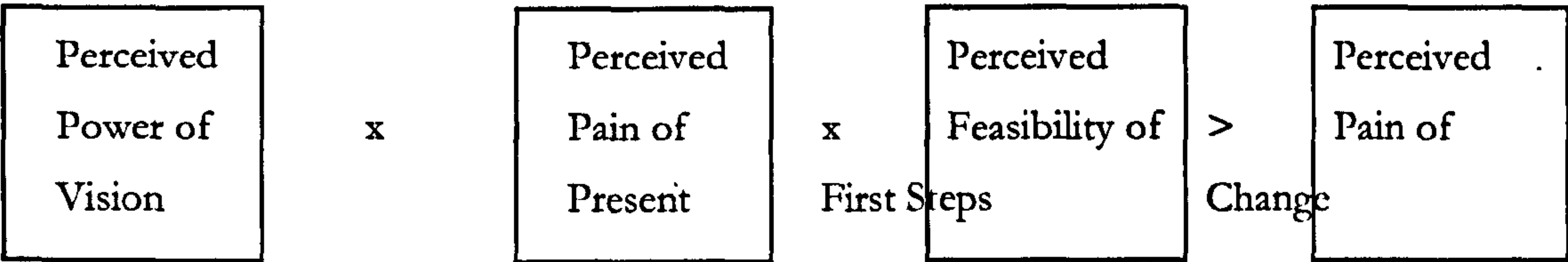
Each model will be explained in turn and then applied to the proposed change of the mainstreaming of complementary therapies. In applying the models, two ‘organisations’ are considered, those of the NHS and complementary therapies. Although this thesis has concentrated almost exclusively on the alterations required of complementary therapies, if the mainstreaming of complementary therapies were to come about inevitably NHS professionals would also need to alter their attitudes and behaviour. Inescapably, in making generalisations, diverse views from within the complementary therapy and NHS communities are over-simplified and homogenised. Nonetheless, this exercise does clarify the issues around the feasibility of mainstreaming complementary therapies.

7.6.1 Beckhard’s change equation

Developed by American academics in management studies at the Massachusetts Institute of Technology in the 1990s, the first model is the simplest. It identifies three key prerequisites to change. First, there must be a clear vision of the benefits that the innovation will bring about. Moreover, these benefits must be of interest to those who need to change. Second, those changing must be dissatisfied with the current status quo. If not, there is little motivation to proceed. And third, the first steps of a clear action plan must be identified. All three need to be greater than the pain of change. Note that the word “perceived” prefaces each element as the actuality may be much

different. As this is a multiplication equation, if any of the first three factors are 0 then the change will not progress.

Figure 7 Beckhard's change equation



(Beckhard and Harris, 1997)

In applying this model to the mainstreaming of complementary therapies, many have put forward their vision of healthcare systems in which complementary therapies and biomedicine work together (Simpson, 2001; Peters, 2002; St.George, 2004). Furthermore, in the literature, there are practical examples of actual working models (Mulkins *et al.* 2003; Scherwitz *et al.* 2004). However, the “pain of the present”, for NHS professionals and complementary therapists does not appear intolerable, as NHS professionals have largely ignored the issue of mainstreaming (Cant and Sharma, 1999) and many therapists are content to stay in the private sector (Andrews *et al.* 2003). “First steps” may appear relatively clear, but not easily feasible. Reducing fragmentation both within and across professions is key, but this increases the “pain of change” for complementary therapists, as internal divisiveness both within therapeutic modalities and across disciplines is high (Boon *et al.* 2004b; Welsh *et al.* 2004). A further significant source of “pain of change” identified in this study would be the shift of perception amongst therapists from general, holistic practitioners to targeted condition experts. Furthermore, other steps pinpointed in this study would include the fostering of the perception that complementary therapies ‘work’ and that therapists are safe in addition to the identification of “effectiveness gaps” in biomedicine which complementary therapy treatments could plug.

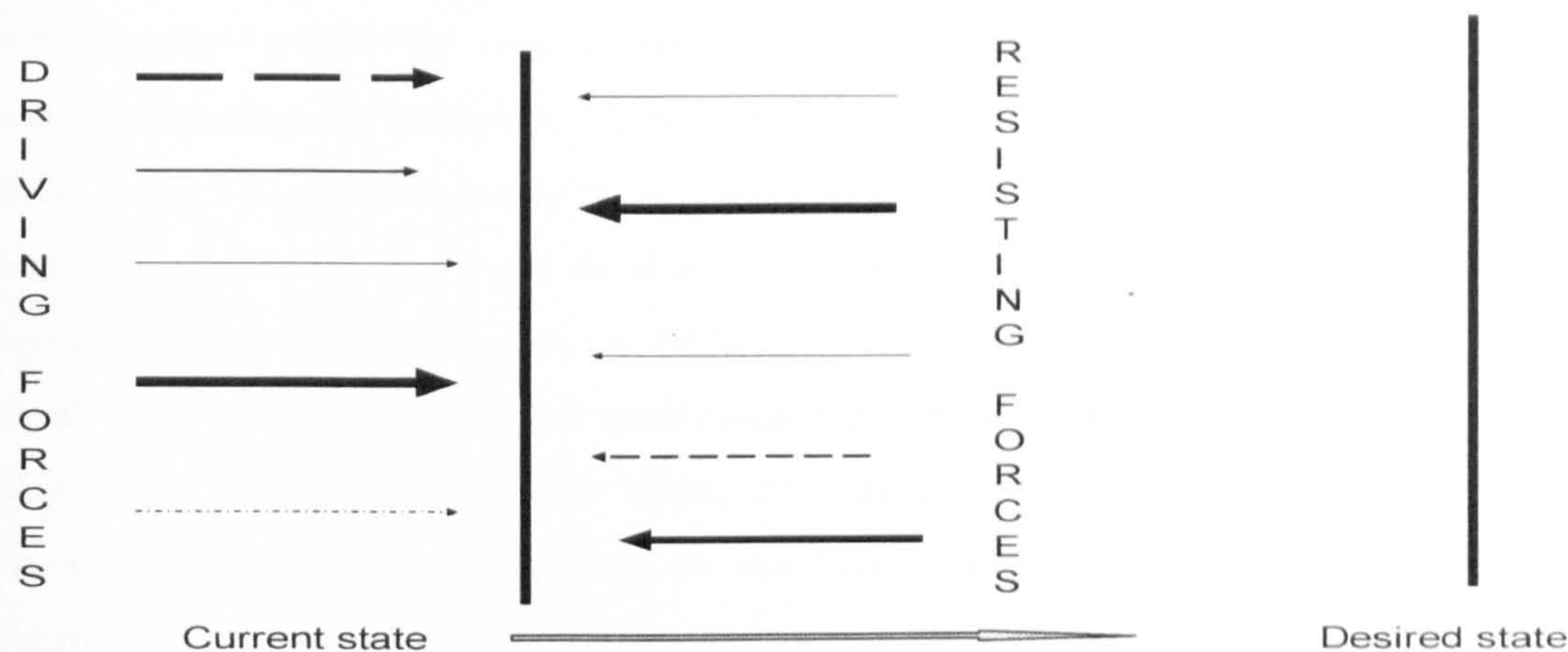
In applying Beckhard's change equation, the two aspects of most concern are the low “pain of present” for NHS professionals and complementary therapists and the high “pain of change” for complementary therapists. Unfortunately, the model does not

theorise as to where efforts should be targeted to make the proposed change happen, but the next model does.

7.6.2 Force field analysis

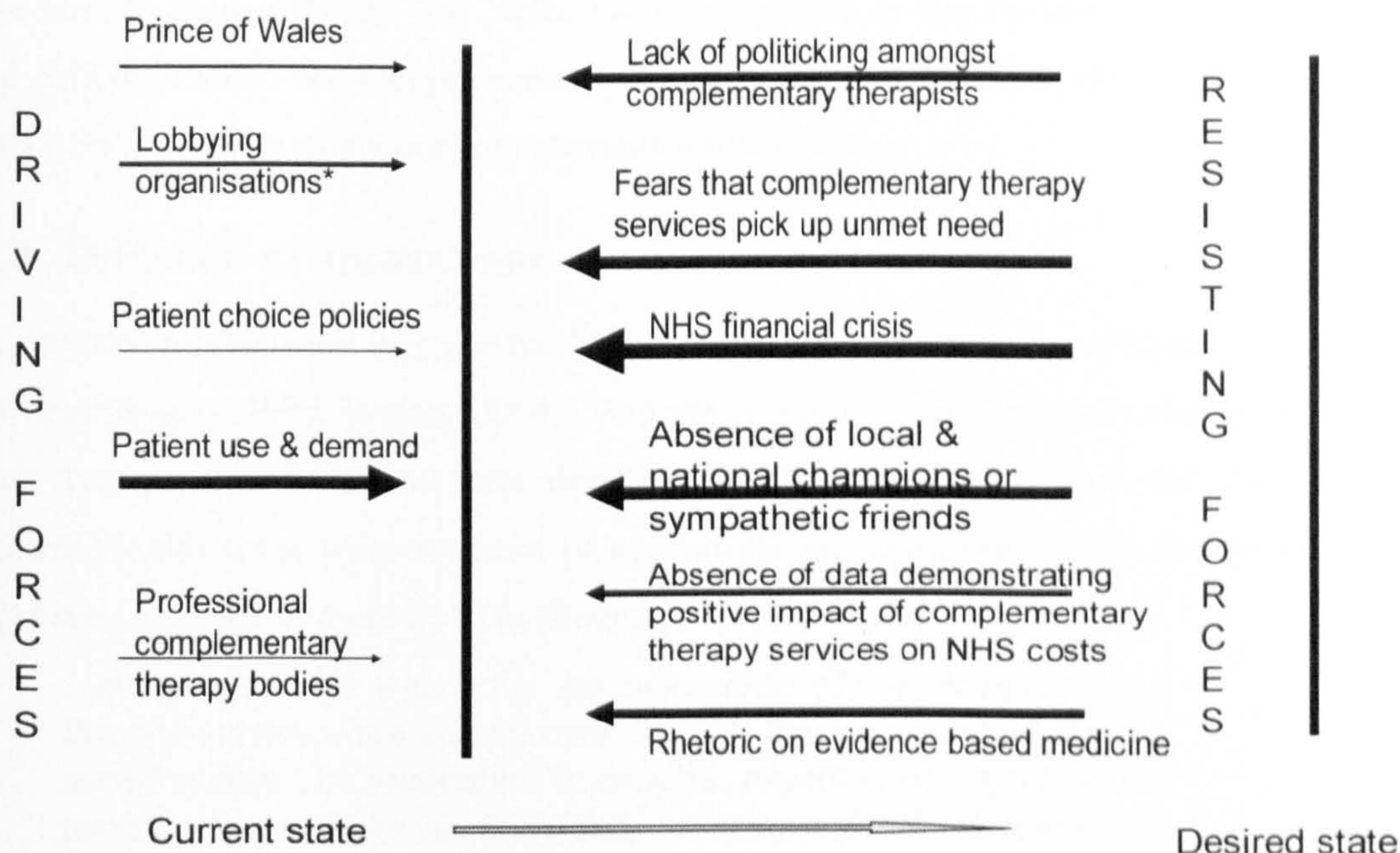
In the 1950s, force field analysis was developed by Kurt Lewin, a social theorist whose work pioneered the fields of psychology and human behaviour. Like the Beckhard model, force field analysis aims to predict whether a proposed change is likely to occur. To do this, “driving” and “resisting” forces of the proposed change are identified. Each force is graded according to its strength; stronger forces are indicated by thicker arrows. For the model to be most useful, a wide range of individuals with varying perspectives should participate in the exercise as objectively and rigourously as possible. Once a force field analysis has been carried out, the resisting forces should be decreased through creative strategies to move towards the desired change. If, conversely, effort is concentrated on increasing the driving forces, further resistance ensues. To bring about social change, the focus is on the value that individuals place on the norms of the collective (Lewin, 1951).

Figure 8 Lewin's Force Field Model



Application of this model could look like this.

Figure 9 Applied Force Field Model to complementary therapies



* i.e. Foundation for Integrated Health, ICAM Unit

Although undoubtedly incomplete, the application of this model suggests that patient use and demand is the strongest driving force, but this study has identified and explored multiple powerfully resisting forces. They include: the lack of politicking amongst complementary therapists, NHS financial crises, rhetoric on evidence based medicine, fears that complementary therapy services pick up unmet need, the absence of local or national champions and the absence of data demonstrating positive impact of complementary therapy services on NHS costs. Little can be done about NHS financial crises, but some energy has been focused on the rhetoric of evidence based medicine by critiquing it (Willis and White, 2004; Barry, 2006) or producing more research (Barnes *et al.* 1999). Furthermore, the Foundation for Integrated Health is attempting to locate and cultivate local champions, like Dr WW and Dr BP, and more attention could be focused on this work. But much more could be done to ensure that evaluations of complementary therapy services include NHS cost data and determine the extent to which 'unmet need' has been picked up. Nonetheless, in considering the implications of this model, there appears to be a lack of resources and talent, although, more positively, much lies within the control of complementary therapists, particularly those already located within the NHS. Having explored in the Beckhard and Force Field Analysis models the receptiveness of the current cultural climate, the next model clarifies the properties of successful innovations themselves.

7.6.3 Diffusion of innovations

The diffusion model is not just one model, but many that have been revised extensively over time (Rogers, 1995; Rogers, 2004). Two are presented here. Originally devised by Bruce Ryan in the 1940s and later developed by Everett Rogers from the 1960s, diffusion models came from research of agricultural practices, particularly the use of hybrid corn amongst farmers in Iowa (Rogers, 2004). Diffusion is defined as:

...the process by which (1) an innovation (2) is communicated through certain channels (3) over time (4) among the members of a social system. An innovation is an idea, practice, or object that is perceived as new by an individual or other unit of adoption. The characteristics of an innovation, as perceived by the members of a social system, determine its rate of adoption (Rogers and Scott, 1997).

The first diffusion model identifies the properties of successful innovations. Rogers defines those as:

- *Relative advantage is the degree to which an innovation is perceived as better than the idea it supersedes.*
- *Compatibility is the degree to which an innovation is perceived as being consistent with the existing values, past experiences, and needs of potential adopters.*
- *Complexity is the degree to which an innovation is perceived as difficult to understand and use.*
- *Trialability is the degree to which an innovation may be experimented with on a limited basis.*
- *Observability is the degree to which the results of an innovation are visible to others (Rogers and Scott, 1997).*

In applying this to the mainstreaming of complementary therapies, the relative advantage for complementary therapies, as perceived by many professional bodies, would be advances in social prestige, employment stability and access to a greater pool of clients (see professional therapy newsletters, journals and websites). For NHS professionals as a group, the relative advantage appears to be a possible increase in patient satisfaction, especially in areas where conventional treatment is failing or negligible, if the intervention can be demonstrated to be without harm at no extra cost. But it is not entirely clear how the mainstreaming of complementary therapies would resolve the more urgent problems within the NHS. However, interestingly, when asked if complementary therapies should be state funded, only one of the 19 NHS professionals interviewed for this study was overtly negative (although a few were reluctantly affirmative). Those who were more enthusiastic listed many reasons in favour of this, including an understanding of the limitations of biomedicine. So at grassroots level where complementary therapy services exist, there is some appreciation of the relative advantage of complementary therapies.

Nonetheless, as discussed in the themes of 'paradigmatic tensions' and 'structural factors influencing service design, delivery and survival', there is little compatibility between biomedical and complementary therapy philosophies, delivery models, diagnoses, treatments or approaches. As the dominant healthcare system, NHS professionals are unlikely to modify their norms greatly to allow for a greater match between the two (Saks, 2003b). But in exploring the two themes of 'similarities and

differences in private and NHS settings', I did find evidence in this study that some complementary therapists, in particular the professional homeopath, were willing to adopt norms of biomedicine. But this may be relatively rare. Perhaps because of these paradigmatic differences, complementary therapies are consequently often perceived by NHS professionals as bewilderingly complex, hence the powerful impact of observation of consultations which was discussed under the theme of 'process factors influencing service design, delivery and survival'. This impression of complexity is reinforced, as the mechanisms of action for many therapeutic disciplines are not grounded in scientific propositions that NHS professionals can accept. More positively, the frequent small-scale provision of complementary therapy services, and their subsequent regular demise, suggests that trialability is high.

Observability is less clearcut. Studies have found that patients often do not tell their physicians of their complementary therapy use (Eisenberg *et al.* 1998; Eisenberg *et al.* 2001; Thomas and Coleman, 2004), so observability would be low. Furthermore, as I found within this study, even if a complementary therapy service is available, it needs to constantly market itself through formal and informal mechanisms to keep its profile high.

Stocking further developed Rogers's work to identify a list of key factors for the diffusion of innovations, specifically in health care. Of particular importance is "minimal requirements for extra resources" (Stocking, 1985). Proponents argue that the costs of complementary therapy provision would be outweighed by the benefits of decreased use of NHS resources (Luff and Thomas, 2000b; Kelner *et al.* 2002), but in exploring the theme of the 'reality of evidence available' in this study, I found that the little evaluative work carried out in this area is inconclusive.

Overall, in considering the diffusion of the mainstreaming of complementary therapies, the property of relative advantage is mixed, while those of compatibility and (lack of) complexity are negligible or missing. Trialability, on the other hand, is (depressingly) common. The degree to which benefits are observed is ambiguous and the impact of the innovation on resources is inconclusive.

Rogers also offers ways to determine where a particular innovation is in the change process. He theorised that over time social change occurs as individuals with differing sensibilities adopt the innovation. Most importantly for diffusion are the early adopters,

who are essential to create a critical mass by testing an innovation to reduce uncertainty and then spreading it through interpersonal networks. In exploring the theme of ‘process factors influencing service design, delivery and survival’, I found that Dr. WW and Dr. BP were key early adopters of the complementary services on their sites, although their efforts were largely exhausted with the continued survival of their own service, rather than its diffusion elsewhere.

So, overall, in applying models of diffusion, the properties of complementary therapies lead to slow adoption and the innovation is now in the stage of creating “early adopters” amongst the NHS community. The next model gives a different perspective on phases of change.

7.6.4 Transtheoretical model of change

In the 1990s, Prochaska and colleagues developed their understandings of the process of change from studies on recovery from tobacco addiction. Although the model was originally developed with individuals as the focus, especially for addictions and exercise, recent work has focused on applying the model to organisational change, especially in social work and counselling (Prochaska, 1998; Prochaska *et al.* 2001). The King’s Fund adapted and applied this model to healthcare organisations adopting evidence based practice (Smith and McClenahan, 1997).

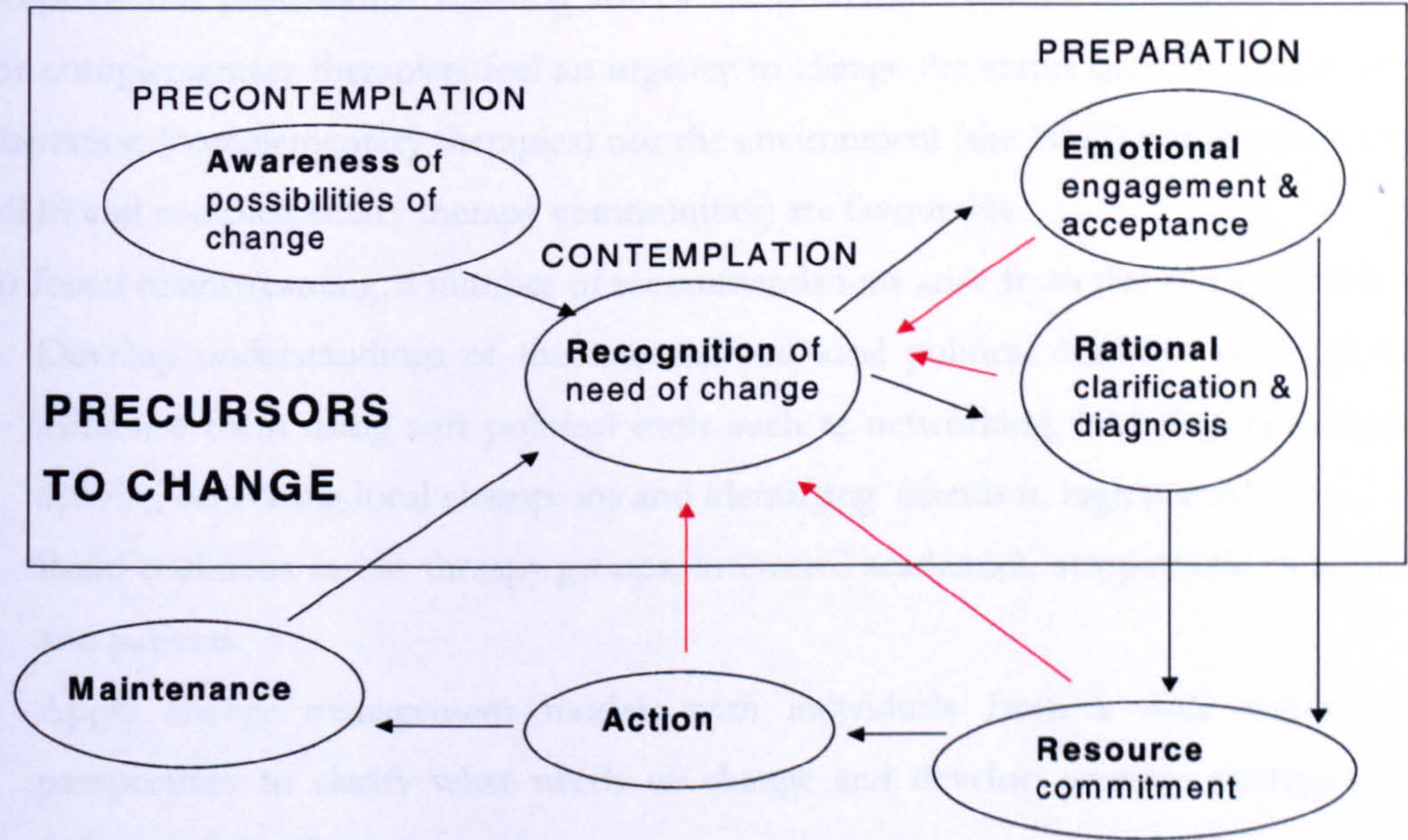
The transtheoretical model postulates that several stages of change are experienced. The first is *pre-contemplation*, in which there is no intention to change in the foreseeable future, largely because although others might believe the behaviour is problematic, those expected to adopt the change do not. The second is *contemplation*, when there is an awareness of the existence of a problem, but no commitment has yet been made to take action. Many become stuck at this stage. If one proceeds, it is to the *preparation* phase, when action is planned to occur with clear strategies within a particular timeframe, but the behavioural change has not yet happened. All of these three stages are “precursors to change” because as yet, no external behaviour modification can be noted.

The next step is *action*, when the behaviour or environment is modified to address the problem; this requires considerable commitment of time and energy. *Maintenance* is the final phase, in which the tendency to relapse is countered and the gains of the action

phase are consolidated (Prochaska *et al.* 1992). In adapting this model to healthcare organisations, we identified an additional stage of resource commitment, to ensure that the change could proceed (Smith and McClenahan, 1997).

Although presented in a staged fashion, Prochaska and colleagues stated that the process of change was non-linear; those in the preparation phase might revisit the contemplation stage several times and even those who had achieved maintenance might “relapse”. Hence black arrows indicate the ideal linear progression of change, while the pink arrows suggest possible non-linear lapses.

Figure 10 Adapted transtheoretical model of change



(Adapted by Smith & McClenahan, 1997)

In applying this model to the mainstreaming of complementary therapies, I would suggest that NHS professionals are in the pre-contemplation phase. Many do not believe or are aware that there is a problem to be addressed, as there appears to be consensus that there is no “strong” evidence of effectiveness, as discussed with the theme ‘rhetoric on evidence based decision making’. Likewise, some complementary therapists are in the pre-contemplation phase, while others may be in the

contemplation phase, with a few even advancing to preparation. But because of many of the paradoxical and challenging issues identified within the themes of ‘structural and process factors influencing service design and delivery’ (e.g. targeting effectiveness gaps without picking up unmet need, identifying and deploying service champions, treating specific conditions with holistic treatments), little progress beyond this point has been made.

7.7 Could complementary therapies be mainstreamed?

Application of change management models suggests that the speed of mainstreaming of complementary therapies is necessarily slow, because the internal properties of complementary therapies do not facilitate their spread, the cultural environment is not receptive and professional resisting forces are powerful. Neither NHS professionals nor complementary therapists feel an urgency to change the status quo. So neither the adaptation (complementary therapies) nor the environment (the NHS) nor the adopters (NHS and complementary therapy communities) are favourable.

To foster mainstreaming, a number of recommendations arise from this study, namely:

1. Develop understandings of the national and local political contexts and seek to influence them using soft political tools such as networking, lobbying, grassroots activity, cultivating local champions and identifying ‘friends in high places’.
2. Build coalitions across therapy groups, interested academics, sympathetic clinicians and patients.
3. Apply change management models with individuals from a wide variety of perspectives to clarify what needs to change and develop creative strategies to reduce resisting forces.
4. Acknowledge that the call for evidence is partly a rationing tool. The production of further evidence is unlikely to influence the mainstream adoption of complementary therapies. Focus efforts accordingly.
5. Include NHS cost data and standardised health outcome tools in all evaluations of NHS complementary therapy services.
6. Commission studies to assess the validity of commissioners’ fears that complementary therapy studies pick up unmet need and create “add on” rather than “instead of” services.

7. Invite NHS professionals to observe complementary therapy consultations.
8. Design a service (as much as possible) along the lines of a 'NHS acceptable' model.
9. Build relationships with more 'patient centred' doctors, especially those in useful commissioning roles, to identify fertile territory for NHS complementary therapy services.
10. Explore options other than the NHS for mainstreaming opportunities, such as local authorities and voluntary and community initiatives.

In the meantime, political, cultural and organisational circumstances may change, or be made to change, and change rapidly, with corresponding effects. For example, recent policy initiatives have emphasised wellbeing and prevention, which may offer a lever (Department of Health, 2006b). New commissioning frameworks have drawn together health and social care (Department of Health, 2007), and social care professionals may be more accepting of complementary therapies within the mainstream. The movement of the NHS from an acute healthcare system to a more American, consumerist model focused on chronic disease could have an impact, especially if NHS patients become more demanding like their American counterparts. Changes in the delivery of complementary therapy treatments from individual to group consultations could make a difference. So now is not propitious, but I agree with Turner,

New configurations of power are producing new systems of knowledge within which CAM [complementary and alternative medicine] will come to play an important but probably unpredictable part (Turner, 2004).

7.8 Conclusion

This chapter has drawn together the themes from across the thesis as a whole and developed the thesis argument. The next chapter gives an overview of the thesis, discusses the strengths and limitations of the study and provides suggestions for future work.

CHAPTER 8 Conclusion

8.1 Introduction

The purpose of this final chapter is to provide a brief overview of the whole thesis and discuss the strengths and limitations of this study. I will discuss the contribution this study has made to research into the field of the mainstreaming of complementary therapies. The chapter concludes by identifying areas for future research and brief concluding reflections.

8.2 Summary of the thesis

The overall aim of the study was to address the question of what adaptations the complementary therapy community would have to make to become mainstreamed into NHS primary care. The study did not set out to determine if mainstreaming 'should' take place, but rather if it would be possible within the current context of the NHS.

This thesis opened with the story of a patient who has 'integrated' (apparently effortlessly) both biomedical and complementary therapies into her personal approach to healthcare. In Chapter 2, I reviewed the literature and set the research question within its context, exploring both the drivers of and barriers to the mainstreaming agenda. This highlighted that although some research had been undertaken, policy oriented studies had concentrated on the trajectories of particular complementary therapy services (at meso or organisational level) while more sociological studies had considered an individual question in-depth e.g. the role of health consumerism (or macro level). The question had not been considered from multiple levels (e.g. macro, meso and micro) concurrently.

Chapter 2 also crystallised the objectives of the study, which were:

- To explore the role of clinical evidence and service evaluations in mainstreaming complementary therapies.
- To determine the structural and process features of a 'NHS acceptable' complementary therapy service.
- To identify changes in complementary therapy consultations delivered in private and NHS settings.

Chapter 3 discussed the methodological approach and methods used to address these questions. Using multiple methods in two case sites allowed for an in-depth exploration of both rhetoric and behaviour. In addition, this approach enabled the questions to be explored from a range of perspectives and sources.

Data from interviews, documentation and observations of consultations from the two case sites were presented in Chapters 4, 5 and 6. Moreover, literature was drawn on to discuss the findings presented in these chapters. In Chapter 7, the findings were pulled together, compared and elaborated to answer the thesis question. Change management models were applied to explore the feasibility of mainstreaming more widely.

The results of this study suggest that the adaptations necessary for the mainstreaming of complementary therapies are wide-ranging and complex. More importantly, contradictions are rife both within the rhetoric and behaviour of NHS professionals and between the two paradigms of biomedicine and complementary medicine. This suggests that complementary therapy services, as delivered by professional complementary therapists, could only become adopted by the NHS in partial, haphazard, ad hoc ways. Nonetheless, I found evidence that complementary therapists can alter their clinical practice to fit NHS expectations, within reason, without a commensurate loss of patient or therapist satisfaction. This leads me to believe that some complementary therapists (or complementary therapies?) are adaptable but that the environment of the NHS is unfavourable. Patients may easily be able to combine both types of healthcare, but organisationally, such merging is fraught with difficulties within the current context of the NHS.

8.3 Strengths, weaknesses and the contribution of this study

The greatest limitation of this study is that no PCT managers from the second site contributed. This was because service providers and clinicians were concerned that including commissioners in this study would jeopardise the service. In the event, funding was cut regardless.

Transferability of findings is also an issue. In Chapter 2, I argued that transferability would need to be audience generated, as it is difficult to explicitly satisfy with case study methodology. With that caveat, having presented these results to a wide range of

individuals, I am relatively confident that the findings of the macro issue around the role of evidence is transferable to other primary care settings, especially as the wider literature supports many findings. I am less confident of the transferability of findings on the features of a 'NHS acceptable' complementary therapy service model and believe this should be tested further. I am least confident of the transferability of the findings exploring the differences in clinical practice in the two settings of the NHS and private practice. This is because only two therapists participated in this study, a limited number of consultations were observed, few complementary therapists are employed in NHS premises overall, the models where such NHS based services exist vary tremendously and the variability in practice amongst complementary therapists, whether working in the NHS or privately, is great. Thus, the findings and conclusions from this aspect of the study need to be taken with reservation.

Despite these limitations, this study included a number of original features – the first of which is the observation of consultations of complementary therapy treatments. I could find only two other completed studies in which observations of complementary consultations took place (Cant and Sharma, 1996; Barry, 2003). Since then, another study including observations of herbal medicine consultations has begun in England (Nissen, 2006). As observational studies of complementary therapy consultations are still extremely rare, this study makes an important contribution.

A second strength of this study is the use of multiple methods. This led to the elaboration and clarification of findings across sources. In addition, this allowed for rhetoric and behaviour to be compared, leading to the identification and exploration of discrepancies, particularly in unearthing the complexities behind referral rates and the call for evidence. As previous studies have tended to take the responses gathered from interviews and questionnaires on this topic at face value, this study is unusual in going below surface representations.

Third, including sets of interviews from NHS professionals, therapists and patients has permitted a variety of perspectives to be explored. Most importantly, the views of a key group, that of English PCT managers, has been heard. Two previous studies with this group have focused on Canadian commissioners or been limited to surveys.(van Haselen, 1998; Kelner *et al.* 2004) A third study interviewed English “lead primary care” commissioners from nine Primary Care Groups (Thomas *et al.* 2004), but this is

the first study in which more in-depth data from a range of English PCT managers from public health, pharmacy and executive positions have been collected.

Fourth, this study is one of the first to utilise change management literature in considering the mainstreaming of complementary therapies. By applying change management models, the mainstreaming of complementary therapies becomes less unique, in that it shares elements with many other proposed innovations, and more specific, as the particular features leading to adoption or rejection are highlighted.

Finally, this study was undertaken by a complementary therapist working at an academic unit of primary health care. A growing number of complementary therapists are conducting research, but this is still relatively rare. Furthermore, of those that do, few actually work alongside GPs, nurses and other biomedical practitioners on a daily basis. This appears to be the first qualitative study of the issues around mainstreaming undertaken by an individual with a foot in both camps. This perspective influenced both the methodology employed and the interpretation of subsequent findings.

8.4 Areas for future work

Having argued throughout this thesis that research makes little difference, there is considerable irony in suggesting further research. However, future studies could fall into three areas.

The first would be to further exploit the data already collected. So, for example, conversation analysis could be applied to data collected from observations of consultations to explore the difference between interactions in the two settings.

The second area would be to confirm findings from this study more widely. To test the replicability of the structural features of a 'NHS acceptable' complementary therapy service model, an update on the national 'mapping survey' (see 2.3.4) could be undertaken. To explore the transferability of findings on the process characteristics of a 'NHS acceptable' service, other sites could be recruited using case study methodology. Another area of research would be exploring the extent to which consultation times can be reduced, without a detrimental effect on satisfaction and perceived effectiveness, by observing the practices of a larger range and greater number of complementary therapists. To confirm and elaborate the change management model

applications, a Delphi exercise could be carried out with a wide range of key individuals.

A third area of future research would take the findings from this study further. In particular, I would propose an ethnographic study of the decision-making behaviour of PCT managers and practice based commissioners, using the same methodology as the study conducted by Gabbay and le May (Gabbay and le May, 2004). A separate study could comprise of selecting several complementary therapy interventions with robust evidence and exploring the barriers and levers to their adoption amongst clinicians and commissioners within the NHS. Alternatively, a study could replicate the methodology of Barry and colleagues to explore patient agendas in NHS and private complementary therapy consultations (Barry *et al.* 2001). As patients are those who are mainly engaged in mainstreaming different types of healthcare, I would suggest further qualitative studies exploring how they make their healthcare decisions and their combined use of over the counter and practitioner provided services, whether biomedical or complementary treatments.

However, perhaps focusing on the dissemination of this study would be more appropriate, before conducting further studies. Targeted dissemination is rapidly becoming expected, particularly by the Department of Health, who request annual reports from academic primary health care departments on how studies have “changed NHS policy or practice in the past 12 months” (personal communication, Jo Pearce).

In particular, I would like to disseminate recommendations to the complementary therapy community through making contacts with professional complementary therapy organisations, including pan-agencies such as the Foundation for Integrated Health and the British Holistic Medical Association. The aim would be to publish short pieces in their newsletters or journals. I would also offer to speak at conferences or to the Boards of the professional groups. In addition to the complementary therapy community, I would like to disseminate messages from this study to:

- The academic complementary therapy research community via academic journals and conferences.
- Sympathetic doctors and nurses through BHMA local initiatives and other grassroots networks.
- Patients through alternative magazines such as *Kindred Spirit* and *The Spark*.

8.5 Concluding thoughts

This thesis was generated from a personal desire as a complementary therapist to explore the extent to which complementary therapy principles, philosophies and practices might be dominated, compromised or left intact within the NHS.

On one hand, what I learnt was inspiring – I found an example of a complementary therapist who appeared to be highly esteemed by her biomedical colleagues. She offered a service, in line with homeopathic principles, that was integral to NHS service provision as a whole. But not only was this therapist exceptional, so were her biomedical colleagues. Unfortunately, this service is now defunct, suggesting it was the exception to the rule.

On the other hand, mirroring the trajectory of this study was my own personal process of becoming ‘mainstreamed’. From the beginning of the study, I have grappled with being an energy therapist, while also working within a highly biomedical environment. In Chapter 3, I wrote that the challenge of mainstreaming was

How energetic and biomedical worldviews could co-exist in the wider context of healing, without one co-opting or neutralising the other.

Three years on, I gave up my clinical practice because my complementary therapist persona had become “neutralised”. Even with the support of both biomedical and complementary therapy colleagues, I could no longer exist comfortably in both worlds. Because of this, perhaps I am overly pessimistic about the possibilities of others avoiding the same fate.

Nevertheless, I feel more resolved that the complementary therapy community should press on with the mainstreaming agenda, not least because the imperviousness of the NHS does both patients and health professionals a disservice. Although this thesis has focused on how complementary therapies would have to change, the NHS would also have to alter its defences to allow complementary therapies comprehensive access. As David Seedhouse, an ethicist who wrote *Fortress NHS*, argues

The secret of preventing change in any system is to stop up all channels through which protests might meaningfully be heard. The NHS has managed to achieve this in practice through a host of direct methods. Its perimeter defences and outer walls are as robust as ever. Indeed it is difficult to overestimate the practical power of those who benefit most from the Fortress....[However] the way to

*dismantle the Fortress is not to hurl stones at it from the outside,
but to show it up for what it is (Seedhouse, 1995).*

This thesis is just one such attempt to “show it up for what it is” or, in other words, to identify and uncover discrepancies, so that hidden agendas and constraints can be revealed. In doing so, my goal is to increase understanding between the two camps and reduce polarisation, hopefully to the advantage of both the NHS and complementary therapy communities – and ultimately patients like Alice.

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Appendix A Information sheet

Delivering complementary therapies in the NHS and privately

Project contact: Lesley Wye

Address: *University of Bristol, Primary Health Care, Cotham House, Cotham Hill, Bristol, BS6 6JL.*

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Invitation to participate

You are being invited to take part in a research study looking at the integration of complementary therapies into the NHS. This study is being conducted at the University of Bristol, as part of a PhD award from the Department of Health. It is taking place between September 2004 and September 2007. Before you decide, it is important for you to know why the research is being done and what it will involve. Please take time to read the following information. Please ask us if there is anything that is not clear or if you would like more information.

What is complementary medicine?

By 'complementary medicine' we mean therapies and treatments that are usually provided outside of the NHS. Examples include homeopathy, acupuncture, osteopathy, chiropractic, herbal medicines, massage therapy, relaxation, aromatherapy, nutritional therapies, reflexology and hypnotherapy. Some of these may be available within the NHS e.g. at Bristol Homeopathic Hospital. But most are provided in private complementary therapy clinics or can be purchased over-the-counter at chemists or other shops.

What is the purpose of the study?

Over 40% of the adult population in England and Wales are estimated to have used complementary therapies at some point in their lifetime. That proportion is increasing. Most users receive treatment privately, but a small number have NHS treatments. There have been recent moves by this government towards integration of complementary medicine into the NHS, yet we know little about how this works in practice. This is why we need you to take part.

Why have I been chosen to take part in this study?

We have written to you because you are a health professional working in an organisation that funds complementary therapy services. We want to include professionals from a wide range of backgrounds to learn more about such services.

Do I have to take part?

Taking part in this study is voluntary. If you decide to take part, I will ask you to sign a consent form and give you a copy of the consent form to keep. You will be free to withdraw from the study at any time.

What will happen to me if I take part?

If you agree to take part, I will meet to conduct a 45-60 minute interview. I will contact you to arrange the best time and location for the interview. The interview will be recorded to keep an

accurate record of what you say. You do not need to do anything to prepare for the interview – I simply want to find out your views of delivering complementary medicine in the NHS. Only the research team will have access to the interview recordings and typed transcripts. We will give you a copy of the interview transcript if you would like it and you will be free to ask us to exclude any information that you have given us.

❏ What are the possible benefits of taking part?

There is currently a lack of information about complementary health services in the NHS. We believe it is important to include health professionals' views on this topic because we need to learn more about the challenges of incorporating complementary medicine into the NHS. For example, what are the implications of incorporating complementary therapy services into the NHS? What are some of the practical difficulties? Your views could contribute to recommendations about delivering complementary medicine in the NHS.

❏ What are the possible disadvantages of taking part?

The only possible disadvantage of taking part is the time cost to you.

❏ What happens when the study ends?

When this study ends, the interview recordings will be wiped and we will not need to interview you again. The results will be written-up for a report to the Department of Health and for publications that will be read by health professionals and complementary therapists. I will be happy to give you a copy of any reports from the research. You will not be identified in any publications.

❏ Will my taking part in this study be kept confidential?

All the information given will be kept strictly confidential. Only the research team at the University will know that you are taking part. Your interview recording and transcript will be given an anonymous identifying code so that no one will be able to identify you. Your name will not be used in any written reports from the research. Your contact details (e.g. name and address) will be stored on a secure database on a computer at the University and will not be passed to anyone else within or outside the University.

❏ Who is organising and funding the research?

A research team from the University of Bristol are organising the study. It is funded by the Department of Health.

❏ Who has reviewed the study?

The study has been reviewed by the London Multicentre Research Ethics Committee.

❏ What do I do now?

We do hope you will be able to help us with this research. If you are willing to participate, please contact Lesley Wye at the University of Bristol, Primary Health Care, Cotham House, Cotham Hill, Bristol, BS6 6JL. ☎ (0117) 954 6686, email: lesley.wye@bristol.ac.uk.

THANK YOU FOR READING THIS!

Appendix B Topic guides

Example topic guide A for a key informant

Interview date 29.9.04

- How long have you been practicing?
- What drew you to homeopathy?
- How did you end up working for a NHS service?
- What worked well?
- What didn't work so well?
- What did you do differently in your clinical practice in the NHS versus privately?
- What would integration look like?
- What needs to change to make that happen?
- Do you use the term healing?
- How does healing fit within the NHS?
- Would you work in the NHS again?
- Anything else?

Example topic guide B for a patient

Site 1

Interview date 11.10.04

- How did you get interested in acupuncture?
- What are the differences between seeing the acupuncturist in the GP surgery or at her home?
- What are the similarities?
- Is the effectiveness of treatments different?
- What is the impact of reduced consultation time?
- Which setting do you prefer and why?
- What are your views on incorporating CAM into the NHS?
- What would the NHS have to change?
- What would therapists have to change?

Example topic guide C for administrator

Site 1 Interview date 24.4.05

- How long have you been working at this surgery?
- Were you around when the complementary therapy service was introduced? If so, what do you remember about that time? Who was involved? How involved were you in setting up and developing it?
- What's it been like having access to this service? What's the impact been on receptionists and the surgery in general? What are the main difficulties? What are the main advantages?
- In the new premises, who and how was it decided where the therapy suite would go?
- Why aren't there any signs?
- How integrated does the service feel? (Christmas party, podiatrists)
- What's the impact of having the service office off site?
- What would happen if service ceased to exist?
- Do you believe there is a legitimate place for this type of services within state funded systems?
- If so, what needs to change to make that happen?

Example topic guide D for a nurse Site 1

Interview date 22.6.05

- What's your role at this surgery? How long have you been working there? Where else have you worked?
- Have you referred to the complementary therapy service?
- What has your contact with the therapists and co-ordinator of the service been like up to now?
- How integrated does the service feel?
- Why do you think practice nurses, district nurses and health visitors refer so little to the service?
- What would it be like if the service stopped?
- What do you think about complementary medicine?
- Does complementary medicine have a legitimate place in the NHS?

- What needs to change for complementary medicine to become part of NHS? (if Y to 8)

Example topic guide E for PCT manager Site 1 Interview date 25.7.05

- What are your own personal views about (and use of) CAM?
- What would you say is the “official” PCT position, if there is one?
- Do you believe there is a legitimate place for these types of services within the state funded system?
- If you do, what would make it easier for PCTs to commission CAM services? What needs to change?
- What type of evidence is needed?
- Are CAM services seen as an ‘add on’ or ‘instead of’?
- Why would it be easier to fund counselling services than CAM?
- What would the impact of enhanced services and practice based commissioning be on the commissioning of CAM services?
- How close are we to the mainstreaming of CAM?
- What changes would mainstream services have to make to incorporate CAM services? (*is this a variation of question 4?*)
- Anything else?

Example topic guide F for a therapist Site 2 Interview date 30.1.06

- How was the service set up?
- Why was it set up? Why are there only three therapies?
- Who was involved – a) leadership, b) champions within the NHS?
- How is it funded?
- Did/ does the design of service reflect the implicit/ explicit preferences of funders?
- What role did ‘evidence’ play in setting up the service? In continuing it? What was the evidence needed? What part did the evaluation play?

- How does the service work? Who refers? How long are the sessions? How many do patients get? How do you communicate with referrers?
- What are relationships with professionals within the NHS like? a) clinic itself, b) referrers?
- Are there any differences in your clinical practice in the NHS & privately? What happens to the extra time?
- Are there differences in the NHS in terms of: a) premises, b) paperwork?
- How has working in the NHS changed you (attitudes, behaviour)?
- Have you noted any changes in your biomedical colleagues?
- Documentation – what's available? Original bid? Contracts? Subsequent bids? Referral data?
- Does CAM have a legitimate place in the NHS?
- Who else do I need to talk to?

Example topic guide G for a doctor

Site 2

Interview date 1.2.06

- Her background – how get interested in CAM? Why homeopathy in particular?
- Personal views on CAM? How long at clinic for?
- Rationale for setting up service?
- Who involved and roles they played?
- Role of evidence in setting up? Kate Thomas's evaluation?
- What challenges?
- Who decided six sessions & length of sessions? Why choose homeopathy and aromatherapy as therapies? Access? Referral criteria?
- What happened to aromatherapy?
- Influence of NHS on setting up the service? Other influences?
- Effect of premises?
- Consistent in her championing?
- How encourage referrals in the beginning?
- How integrated is the clinic w/in NHS (scale 0-10)? What needs to happen to make it more integrated?

- PCT attitudes & key people then & now?
- Turnover in PCT & clinic?
- What makes this service special?
- Does CAM have a legitimate place in NHS?
- If advising someone else setting up a CAM service somewhere else, key ingredients?
- Anything else?
- Anyone else should talk to?

Appendix C Audit trail for interviews and observations

Table 13 Details on collection of interview and observation data

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 1	1	NHS	Current Co- ordinator	Key service provider	5.7.04	F2F	LW	Jan 06
Interview 2	Key informant	Therapist's home	Therapist	Previously worked at other NHS CAM service	6.7.04	F2F	External	Sept 05
Interview 3	Key informant	Therapist's home	Therapist	Previously worked at other NHS CAM service	8.7.04	F2F	Not transcribed (1)	----- --

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 4	Key informant	Therapist's clinic	Therapist	Adamantly opposed NHS employment to	22.7.04	F2F	LW	Sept 05
Interview 5	1	Therapist's home	Therapist	Initially interested in being observed	21.9.04	F2F	External	Sept 05
Interview 6	Key informant	Telephone	Therapist	Previously worked at other NHS CAM service	29.9.04	T	LW	Sept 05
Interview 7	1	Therapist's home	Observed therapist 1 st interview	Volunteered to be observed	30.9.04	F2F	LW	Sept 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Observation 1	1	NHS	Observed patient 1	Experienced both private & NHS treatments	5.10.04	----	LW	Nov 05
Interview 8	1	My home	Patient	Observed both privately & in NHS	11.10.04	F2F	LW	Sept 05
Observation 2	1	Private clinic	Observed patient 2	Experienced both private & NHS treatments	11.10.04	----	LW	Nov 04
Observation 3	1	Private clinic	Observed patient 1	Experienced both private & NHS treatments	18.10.04	----	LW	Nov 04

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Observation 4	1	NHS	Observed patient 2	Experienced both private & NHS treatments	19.10.04	----	LW	Nov 04
Interview 9	1	Patient's home	Patient	Observed both privately & in NHS	20.10.04	F2F	External	Sept 05
Observation 5	1	NHS	Observed patient 3	New patient	2.11.04	----	Not transcribed (2)	Mar 05
Observation 6	1	NHS	Observed patient 4	New patient	2.11.04	----	Not transcribed (2)	Mar 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 10	1	Telephone	Patient	Experienced treatments both privately & in NHS	29.11.04	T	LW	Sept 05
Observation 7	1	NHS	Observed patient 5	Booked in on day selected for observation	30.11.04	----	LW	Dec 04
Observation 8	1	NHS	Observed patient 6	Booked in on day selected for observation	30.11.04	----	LW	Dec 04
Observation 9	1	NHS	Observed patient 7	Booked in on day selected for observation	30.11.04	----	Not transcribed (3)	Mar 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Observation 10	1	NHS	Observed patient 4	Booked in on day selected for observation	30.11.04	----	Not transcribed (2)	Mar 05
Observation 11	1	Therapist's home	Observed patient 8	Booked in on day selected for observation	1.12.04	----	LW	Jan 05
Observation 12	1	Therapist's home	Observed patient 9	Experienced both NHS and private treatments	1.12.04	----	LW	Jan 05
Interview 11	1	NHS	+Practice nurse – 2 nd surgery	Willing to be interviewed	Autumn 2004?	F2F	External	Sept 06

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 12	1	NHS	+Practice nurse – 2 nd surgery	Willing to be interviewed	Autumn 2004?	F2F	External	Sept 06
Observation 13	1	Therapist's home	Observed patient 10	Booked in on day selected for observation	16.12.04	----	LW	Jan 05
Interview 13	1	Therapist's home	Observed therapist – 2 nd interview	Discussion of preliminary analyses	20.1.05	F2F	LW	Sept 05
Interview 14	1	Telephone	Patient	Observed both privately & in NHS	26.1.05	T	LW	Sept 05
Interview 15	1	Telephone	GP 1 st surgery	Service advocate	26.1.05	T	LW	Sept 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 16	1	His office	Chair of original service steering group	Knew background to setting up of service	21.2.05	F2F	External	Feb 06
Interview 17	1	Telephone	GP 1 st surgery	High referrer	24.2.05	T	LW	Sept 05
Interview 18	1	Telephone	PCT Manager	Current line manager for service co- ordinator	3.3.05	T	LW partially transcribed *	Jan 06
Interview 19	1	NHS	GP 2 nd surgery	Attended service meetings – presumed enthusiast	9.3.05	F2F	LW	Sept 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 20	1	Telephone	PCT Manager	Representative of health authority on original steering group	10.3.05	T	LW	Feb 06
Interview 21	1	His office	PCT Manager	Chief Executive of PCT	5.4.05	F2F	External	Jan 06
Interview 22	1	Telephone	Practice Manager 2 nd surgery	Only practice manager willing to be interviewed	25.4.05	T	LW	Jan 06
Interview 23	1	NHS	Therapist	Member original steering group	4.5.05	F2F	External	Sept 05

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 24	1	Telephone	Health Visitor – 1 st surgery	Low referrer	22.6.05	T	LW	Jan 06
Interview 25	1	Telephone	PCT Manager	Pharmaceutical manager – reputed to be sceptic	25.7.05	T	LW	Feb 06
Interview 26	1	Telephone	PCT Manager & Doctor	Chair of Professional Executive Committee	25.7.05	T	Not transcribed (2)	Jan 06
Interview 27	2	Telephone	Observed therapist	Interested in being observed	30.1.06	T	External	Sept 06

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 28	2	NHS	Head of service & doctor	Responsible for current running of service and lowest service referrer	31.1.06	F2F	LW	Sept 06
Interview 29	2	University	Former head of service & doctor	Responsible for setting service up	1.2.06	F2F	LW	Sept 06
Observation 15	2	NHS	Observed patient 11	Booked in on day selected for observation	1.2.06	----	Not transcribed (1)	Feb 07

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Observation 16	2	NHS	Observed patient 12	Booked in on day selected for observation	1.2.06	----	Not transcribed (1)	Feb 07
Observation 17	2	NHS	Observed patient 13	Booked in on day selected for observation	1.2.06	----	Not transcribed (1)	Feb 07
Observation 18	2	NHS	Observed patient 14	Booked in on day selected for observation	1.2.06	----	Not transcribed (1)	Feb 07
Observation 19	2	NHS	Observed patient 15	Booked in on day selected for observation	1.2.06	----	Not transcribed (1)	Feb 07

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Observation 20	2	Private clinic	Observed patient 16	Booked in on day selected for observation	2.2.06	---	Not transcribed (1)	Feb 07
Observation 21	2	Private clinic	Observed patient 17	Booked in on day selected for observation	2.2.06	----	Not transcribed (1)	Feb 07
Observation 22	2	Private clinic	Observed patient 18	Booked in on day selected for observation	2.2.06	---	Not transcribed (1)	Feb 07
Interview 30	2	NHS	Doctor	Highest referrer	15.5.06	F2F	LW	Sept 06

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 31	2	Therapist's home	Nurse & therapist	Formerly delivered aromatherapy service	16.5.06	F2F	External	Sept 06
Interview 32	2	NHS	Therapist & doctor	Homeopath delivering service	16.5.06	F2F	External	Sept 06
Interview 33	2	NHS	Doctor	Service referrer	17.5.06	F2F	External	Sept 06
Interview 34	2	NHS	Administra- tor	Responsible for allocating referrals and day to day running of service	17.5.06	F2F	LW	Sept 06

Interview/ observation number	Case site	Place of data collection	Role	Reason for selection	Date interview/ observed	Type	Who transcribed	Initial coding/ analysis
Interview 35	2	Telephone	Patient	Experienced both private and NHS treatments	23.5.06	T	LW	Sept 06
Interview 36	1	University	Doctor	Low referrer	7.6.06	F2F	LW	Sept 06
Interview 37	2	Telephone	Patient	Experienced both private and NHS treatments	20.6.06	T	LW	Sept 06
Interview 38	2	Telephone	Patient	Experienced both private and NHS treatments	20.6.06	T	LW	Sept 06

+

Interviews carried out by Ali Shaw as part of her study on complementary therapies and asthma.

F2F

Face to face interview

T

Telephone interview

- Not transcribed (1) Because interview data not helpful or because transcription of observation data did not answer focus of inquiry
- Not transcribed (2) Mini disc player did not record/ technical problems with sound quality
- Not transcribed (3) I could not understand patient's accent
- Partially transcribed* Mini disc from second half of interview only picked up interviewer's questions not interviewee's responses

All interviews re-coded November 2006.

Appendix D Example of merged field notes and transcription document

10:10 appointment, 2nd of 4 that I'm observing today, 30.11.04, NHS setting.

Client, elderly gentleman, uses a cane, dressed in a full suit with a waistcoat, problems with hip & knee, becomes apparent that has partial hearing loss as can't pick up words unless being spoken directly to. Extended access client. Has had multiple appointments.

00:00 client enters room and immediately starts talking about smoking and recent stresses. He's standing up at the corner of the room by the coat hanger and moves back and forth from in front of the window, which is quite close to where the therapist is, to the coat hanger.

[can't remember if I introduced myself when he came in. Don't think we shook hands as I was in another corner of the room fiddling with the tape.]

00:00 client: --- cigarettes and take this--- out?

00:03 therapist: why?

00:04 client: I think it's frustration that I can't move that I haven't got enough money for the rent. -----I didn't want to go and take anything possible. I'd have to chance it within two lots of days but uh with friends but I've had (client sighing) enough of that (I know). But ----- Bridgewater.----But I turned around to Walter --- But I don't want to leave the friends I got here and start again down there and that would be it. [as soon as client comes in, he starts talking about what is worrying him most, even before he sits down. Initial pleasantries probably occurred downstairs as therapist greeted him & led him to the consulting room. Can't hear a lot of this b/c client speaking softly & lots of whirring on machine. He also speaks quickly as if bursting with what he wants to say. As consultation goes on, client speaks more slowly and less often.]

00:43 therapist: Mind you with your social skills it wouldn't take you long to make new friends.

00:47 client (client laughing) I ain't got no social skills. (both laughing)

00:52 therapist: You do, you do! you might not call them social skills but you've got them. (pause) Well I'm really sorry to hear that [client's name].

00:57 client has taken off his coat. And is standing with his back to the therapist.

1:01 client: Pardon?

1:02 therapist: I'm really sorry to hear that. [therapist genuinely upset]

1:04 client: yeah, well. That's life. You just accept it, that's all. I found, I found a lovely little flat too. But they wanted, they wanted 6 months' in advance. Six months' in advance (hm) plus X amount per week. And I just couldn't go so high. A lovely place. Up by [name] park. Really lovely up there (14 sec pause)

1:38 starting to take off clothes before sitting down, therapist is sitting down and asking questions while client is in the other part of the room. Client goes over & sits down in chair.

1:58 therapist: how's your hip and how's your shoulder? [therapist introduces physical component. Usually clients start off with summary of physical symptoms but this one starts off immediately with emotional situation. Unusual.]

2:00 client: sorry?

2:01 therapist: how's the hip and how's the shoulder?

2:03 client: um I don't know. The shoulder's alright. The shoulder's quite alright. But it's in the hip I've been getting, I think I've done too much. You don't [place] very well, do you?

2:23 *client sitting down w/o shirt on but w/ trousers on* [makes an incongruous sight. Client seems perfectly happy to have stripped down with me in the room.]

2:24 therapist: not really.

2:24 client: You don't know the cemetery at the top?--- view? ---- view? No. There's this cemetery at the top of this hill. Well it's up towards [name] park but from there down to the river there's a lane, [name] lane. (what?) [name] lane. It's mostly overgrown and the top part is tarmacked and bottom part is paved but in between it's all rough, you know rivules where the water's been running down over the hill like. The other morning, last Thursday, I walked along the river I thought I'll go as far as I can. It's a nice day to go for a walk. I felt I was getting lazy and I was also frustrated and I had other places to go too but I thought no I'm going. I walked along the river. And I got to this little turn off went through and oh yes [name] lane. I'll try that. Now you know [name] Hill? (yes) Yeah it's nearly as steep as that. And it took me (pause) it took me what three over three quarters of an hour to get up there but I did it. But (client coughs) on the Friday I was alright but on Saturday I've started electric shocks right through, right through burning two bones and the joint. And I went out Saturday and went over to [place] and on the bus and on the way back huge it was electric shocks like (hm). Terrible. Anyway other than in the night time they're not too bad. Sunday morning I had a couple of twinges but other than that it's settled down. But I think I might have done too much on that Thursday. [very long story. Possibly the longest story I've heard a client recount. Full of details.]

Client uses hands a lot when he talks

4:00 *pointing to R hip while explaining about electric shocks*

4:36 therapist: it's settled down a bit now has it? [client keeps on speaking and ignores question]

4:37 client: and this, this round and round the patella, round the knee cap. Doesn't make any difference which way I turn in bed on this side or on the outside leg on there, I keep moving because it hurts so much. Aches so much. Not hurt, ache. And over on the other side it's just as bad now.

4:45 *touching knee, calls it the "patella". Why use the anatomical term?*

5:02 therapist: so you're not really sleeping either? [therapist asks sleep question, but not diet]

5:04 client: I haven't been sleeping for ages and ages and ages. The only time I've slept really is when I went out one day. I had too many to drink. I came home. 3 o'clock. just

said to Anne as I'm leaving. Hello, Anne. I'm going to bed. That's all I said. I went straight upstairs. 3 o'clock and I didn't wake up until 11 o'clock at night. That's the first solid sleep I've had without you know.[what's this "you know"?] (did you feel okay?) I enjoyed that. (both laughing) But I couldn't do it everyday. That --- the next morning and it weren't too bad and. (pause) so you aren't moved yet? [does client ask this because he's talked so much so far? Don't think client would do this if talking to a doctor. What is it about the relationship that fosters reciprocity in conversational exchanges as well as in terms of working together?]

5:13 therapist takes notes while client talking

5:32 client asks therapist a personal question – "so you aren't moved yet?" She murmurs something and they go back to him.

5:50: therapist: well it's all up in the air at the moment. (4 sec pause) [is she waiting for him to ask more? She turns back to him.] So would you like me to work on your hip today? (yes please, yes please) [therapist agreeing with the client what the priority is] When it hurts you there does the pain go down?

6:08 client: no it's just like a sharp pointed knife coming from inside up through, up through, just between the bones there that's all. (yes) between them

6:21 "sharp pointed knife". Client asks about therapist's daughter. Might know each other personally. Therapist sent him a birthday card. Interesting that she's crossed that boundary.

6:23 therapist: okay well let's see if we can do something with that. (yeah, okay yeah, yeah)

6:29 client: how's [name of therapist's daughter]? [again client asks personal question]

6:30 therapist: she's alright thank you.

6:31 client: oh thank you for the Christmas, birthday card (you got it then) I did give you a ring. (yes you did, thank you.) Thank you very much. I liked it. [therapist sending b-day card seems to indicate that the relationship more than client-patient]

6:42 therapist: did your birthday pass off okay?

6:45 client: uh, yeah. Very quiet. Very quiet. I had one pint. That was all. No whiskey. I didn't have my usual cigar. (36 sec pause)

7:10 client taking off socks and trousers. I'm not looking at him while he's undressing to give him privacy.

7:35: therapist: I won't ask you what your fag intake has gone up to. (therapist laughs)

7:40 client: I just told you (client laughs)

7:42 therapist: you said it had gone up.

7:44 client: between 40 & 60 a week. (6 sec pause)

7:51 Client on couch

7:51 therapist: (therapist sighs) in terms of stress (both laugh). It doesn't do any good. I've told you that before. Lie on your side please. [therapist treating this client's slide into self-damaging behaviour v. differently. Seems to be sympathetic to it. This bit about it doesn't do any good said jokingly.]

8:06 client: yes, that's it just there. (14 sec pause)

8:10 *client lying on L side, while therapist touches his hip*

8:22 client: Taking up walking, taking that hill. It more than, it more than stretched those muscles too. Oh that hurt. Still they settle back.

8:37 therapist: is it the same in the hips?

8:39 client: tender. Tender round there. Just there it is. (okay) (3 sec pause)

8:50 therapist: well, I'll do what I usually do. I'll go for some of the main points around here. And you can guide me where you want the needles. (15 sec pause) [going straight in w/o taking pulses]

8:56 *"tender round there" client touches with his hand. Therapist "you can guide me with the needles" – client giving essential feedback.*

9:00 *therapist opens box of needles*

9:15 therapist: have you talked to the Housing Benefit Office? [example of practical advice]

9:17 client: no I haven't.

9:20 therapist: oh really? (client sighs) You should.

9:25 client: I was leaving that as a last resort.

9:27 *1st needle in*

9:28 therapist: why?

9:31 client: oh, I don't know.

9:35 therapist: you've been paying your taxes all these years. You could do with the help. Well if people are charging an unfair rent, [waiting for client to disagree?] (3 sec pause) then they can be challenged on it. (yeah) If the rent is too much. (14 sec pause) [therapist guessing at reasons why client not going to Housing Benefit. Perhaps it's because he doesn't really want to move.]

10:10 therapist: okay show me where the pain is. In there?

10:14 client: (hm mm), it's more like here. Around here. It hurts more. (11 sec pause)

10:19 *client points to where tender & therapist puts needle in. 2nd needle in . Every time therapist twists needle, client jumps.*

10:32 client: uuuhh. That's it. [he's obviously in pain when the needle goes in.] Hope we're not going to get a bad report mind? (said to me) [interesting that client sees my role as more of one of clinical governance, which I suppose it's setting the ground for.]

10:39 LW: no I feel like holding your hand. (LW laughs) I know what it's like.(4 sec pause)

10:47 therapist: has the feeling changed since that needle went in, [client's name]?

10:52 client: I don't think so. Oooh. That's there. [what's the right answer?]

10:58 therapist: okay let me go down to your knee now. (9 sec pause)

11:09 client: it seems to be more on the top of the patella. Up around here.

11:14 therapist: is that the sorest bit?

11:17 client: That's the sorest bit. .

11:21 therapist: I don't really want to needle in there. I'll do some (---- time)

11:27 therapist: I know. I know, the tendon gets tight. (7 sec pause)

11:32 therapist feels along his right thigh and puts her hands on knees, therapist feeling along.

11:37 client: I didn't think I was going to make it. I was sat, was sat in the window watching the birds. I was all ready. It was just that I left it too late like, you know. I was just too busy watching the birds in our garden. [while I was observing, I very much felt sympathy & compassion for this client. But on re-reading & listening to the tape a few times, I realise that he often interjects anecdotes along the "poor me" line. Perhaps he's not conscious of this. Or maybe he feels he can only get attention if ill. Worries me that so many people think they have to be ill to justify their needs for care.]

11:49 therapist: do you know what I saw the other day? You know those two peregrine falcons in the [place name]? (yeah). I saw them flying.

11:56 client: oh! Well done! (pause) Where were you? [place name] up on [name]? By the [place name]?

12:07 therapist: I was just about to go up to the Chinese restaurant (oh yeah). And they swooped right along the river and up over the [name] road and off into the woods. (20 sec pause)

12:32 3rd needle in knee and client jumps when therapist twists it

12:37 therapist: Tell me when you feel this

12:39 client: uh yeah

12:42 therapist: are you quite comfortable? Do you want me to adjust

12:44 client: no, no. No I'm alright, ta. I'm alright. (6 sec pause)

12:54 therapist (to me): [client's name] knows this whole [name] country, Lesley. Walked all over. (have you?) [calling to aspect of competency of client. Is this to help create a bond with me or to remind him of what he does well?]

12:59 client: I used to. (client laughs) Wish I still could. (3 sec pause)

13:07 LW to client: so do you know lots about birds and things like that? (yeah) Yeah, see I don't know very much. I'd love to know more. [I didn't have a clue what to say but felt I was colluding with it.]

13:11 client: birds, trees, animals, all sorts. (11 sec pause)

13:28 4th needle in R ankle

13:28 client: two peregrine tits came to our bird table. (did it?) A few greenfinches. There's a wren around somewhere but I haven't seen him. I can hear him but I can't see him. You can hear a wren by its ---.

13:46 therapist: can you feel this? (yeah) (12 sec pause)

14:01 client to me: I think she uses me as a voodoo dolly. (client laughs) [almost this entire section of birds to voodoo dolly about including me in some way.]

14:04 LW: you? Makes your hip better. (11 sec pause)

14:12 5th needle in R foot

14:19 client: ooh. (sharp intake of breath because of pain)

14:20 therapist: ---- (yeah) (48 sec pause)

14:47 6th needle in R ear. Therapist cleans up bits and pieces.

15:11 therapist: how's it feeling round here at the moment?

15:15 client: still tender, well that's tender. Tender all right

15:20 therapist: do you feel it would benefit from some heat? [again therapist looks to client for guidance on what to do. This whole session very patient centred as client has to tell therapist where to put needles in as well.]

15:23 client: yeah, yeah, it could do. (Let me try that). I've started, I've started using the hot water bottle as I've sat down of an evening.

15:30 therapist: and does that relieve it a bit?

15:31 client: yeah, yeah. A bit, yeah. 'til I go to bed. (47 sec pause)

15:35 therapist touching round his hip.

15:58 therapist takes out blowtorch to light moxibustion and then blows on it.

16:25 therapist: okay I'll put some heat around each of these needles now. Just tell me when it gets too hot, [client's name]. (12 sec pause)

16:31 starts circling needles with moxibustion

16:44 client: that's a nice temperature. I could use that in liquid bottle all the year round.

16:47 therapist: it would be nice, wouldn't it?

16:49 therapist: I'll just heat it up a little bit more. (14 sec pause)

16:55 Blowtorching moxibustion again.

17:06 therapist: are you feeling warm enough? You can have a blanket over

17:08 client: no, no, I'm alright. (18 sec pause)

17:24 moxibustion is making me feel relaxed. Still circling same needle. Client's thigh twitches when she circles.

17:28 therapist: just say when it gets too much. (20 sec pause)

17:50 client: ugh.

17:57 client: that's a bit warm. (4 mins 25 sec pause)

18:02 goes on to circle needle in top of his hip. She didn't check his tongue or his pulses – why not?

18:46 client jumps

19:09 circling 1st needle again and then going back to needle on hip

19:40 therapist pulls chair over so she can sit down and circle with moxibustion a different needle in the other side

20:32 I take a deep breath in. I feel v. sleepy. Energy change. Tension draining from the top of my head down. Is the smell of the moxibustion affecting me? My eyelids feel very heavy. [felt almost hypnotised here. Can almost sense it again even just writing about it.]

21:39 client still has eyes open. Pretty amazing (? Can't quite read my writing)

22:25 still circling with moxibustion

22:25 therapist: does the heat make it feel any easier?

22:37 client gives big sigh

22:27 client: yes, yes. (good) (94 sec pause)

22:56 still circling b/t the two points. Doing a figure of 8, Always goes round top needle in a clockwise direction

23:41 zigzagging moxibustion down client's thigh

24:04 therapist: is that okay, [client's name]?

24:05 client: yes, yes, yes, that's fine. (9 sec pause)

24:17 therapist: I'll just slide my hand under your knee. Let it go now. That's it. (2 mins & 14 secs)

24:20 therapist puts her hand on client's knee while circles top needle in hip with moxibustion and then back to lower needle in thigh again

26:16 still circling while holding his knee

26:28 therapist sits on couch and goes round client's knee with moxibustion [except for therapist checking twice to make sure that client is comfortable, almost no speech between them for nearly 10 minutes. Lots of silence. Which is interesting because I imagine this client experiences lots of silence anyway. All the breaking of the silences therapist initiated.]

26:36 therapist: I've got to turn that radiator off as well. It's driving me crazy. God, the plumbing in here is awful.

26:45 therapist turns off radiator. I feel anxious again that this tape is not working.

26:48 client: did you come to the opening last week?

26:49 therapist: no I didn't. I missed it. How...?

26:52 client: I forgot all about it. (did you?) I forgot all about it. ---- (25 sec pause)

27:23 therapist: so why did you want the housing benefit people to be the last resort, [client's name]? [therapist often seems to wait until clients very relaxed to bring up most burning question (no pun intended here with the moxibustion – but maybe there is) for them]

27:26 client: I don't know really. I don't know really. Probably because I don't trust the corporation. (client laughs)

27:34 therapist: there are some good people working there. They're a shambles, but there are some very well-intentioned people there. [she doesn't let him get away with that.]

27:41 client: oh yeah, doubtless. It's the organisation. (I know) Or disorganisation. Or disorganisation, (I know) should I put it that way?

27:52 therapist: I know. But with perserverance. I'm sure you could get something sorted out. (23 sec pause) [is it about this? Or is it about having to ask for help?]

28:18 still holding his knee and circling knee with moxim

28:19 therapist: does your landlady know how you feel?

28:22 client: oh I think she's got a funny idea about it but I don't know whether she has. She hasn't mentioned anything though. Well maybe I've let a couple, a couple of little things slip. (18 sec pause)

28:43 therapist presses fingers into client's knee and uses moxim

28:53 therapist: well you know what I think. You must look after yourself. (hmm mm) [why does therapist feel the need to say this when the client hasn't asked for her opinion?] And a lot of people round here know you and --- (oh yeah, yeah) (5 sec pause) I really hope something comes together for you.

29:21 client: what will be, will be. That's it, philosophical. (68 sec pause)

29:32 therapist gets chair to sit down and presses her fingers in while tracing with moxim – still on knee. Perhaps knee getting lots of attention b/c she wasn't very happy about needling it

30:34 therapist: so maybe keep it down to 1 in 5s this week. [I get the sense this really isn't about advice but a way of reconnecting with the client after the last exchange.]

30:36 client: sorry?

30:37 therapist: keep it down to 1 in 5s this week. In your hill walking.

30:45 client: yes, yes (therapist laughs) Definitely. Well I shan't do it again. I just did it out of pure cussedness really. I just wanted to prove to myself that I could still do it. No matter how long it took. I felt myself getting lazy and not doing so much walking as I should do. Or I feel as if I've not, but then again I went over to [place name] a few weeks ago and I walked around for an hour, or less than an hour I think and I caught the bus back home. I just didn't feel like it any more. My leg started aching. The muscle's started pulling at the back of my legs. Oh ---, let's go home. Shouldn't do. I should carry on regardless. (oh I don't know, maybe with lots of ---) ----I should go as far as I can. [client wrestling with difficulties of aging. Seems to think that if he keeps on pushing himself, he'll still be able to postpone effects of aging. Berating self. Is this genuine? An unconscious call for sympathy? Both? Effect is to immediately re-engage therapist's concern.]

31:56 therapist: do you stop and have a cup of tea?

31:59 client: oh yeah, yeah, yeah, yeah. When I go out on Saturdays it's always have a meal when I go out. (55 sec pause)

32:12 *I feel so sad. God what do we do to our old people? Lovely man, trying so hard to keep going. But lonely & in pain. Can't find a safe space to live. Doesn't have enough money. Can't do the walking he enjoys b/c he's in too much pain. He just needs a big cuddle. Is therapist touching him lots b/c this might be the only physical touch he gets from anyone?*

33:00 therapist: Just say when it's ---. I'm going to do it a few times in this spot. (18 sec pause)

33:22 therapist: no?

33:24 client: yeah (client laughs) I don't --- but please don't burn me. (4 mins & 37 sec pause)

34:04 *therapist stands up and briefly traces moxibustion on his foot*

34:24 *back to tracing hip*

35:02 *cut end off moxibustion in wash basin*

35:15 *rubbing oil and taking needles out. Rubs hands all over hips and down thigh while taking needles out.*

35:56 *more oil in hands & on side of L calf*

36:18 *all needles from leg out and therapist rubbing hands along leg from small of back down to toes, shakes fingers out at end. Pulling it off GB meridian – 4th toe.*

37:53 *holding both hands on either side of knee without moving*

38:03 therapist: (client sighs) [energy change for client?] are you okay, [client's name]? Completely comfortable?

38:07 client: yeah, it's just that I'm a bit stuffed up this morning, that's all. It's the catarrh from smoking these cigarettes. That's what that is(hmm) *When he said he'd been smoking again, was that to stop therapist from looking at his tongue?* [client brings up smoking again.]

38:18 therapist: (therapist laughs) tut tut

38:21 *continues stroking thigh*

38:22 client: the answer is in my hands, isn't it? [was he just talking about giving up smoking or also about living situation?]

38:24 therapist: Isn't it hard? It's your situation, in fact, isn't it?. It's been bugging you more and more. Your situation at home has been increasingly (said louder)

38:37 client: yeah it's getting a bit fraught, you know. See what happens in the New Year, I say. --- Christmas.

38:53 therapist: Christmas doesn't half mess things up. (hmm?) Christmas doesn't half mess things up (said louder)

38:55 client: yeah, yeah , yes, it certainly does. (38 sec pause)

39:28 *holding knee with both hands again. I'm finding it hard to concentrate.*

39:38 therapist: on this leg, the needle doesn't hurt so much does it?

39:44 client: no it doesn't hurt at all. (well tell me, tell me roughly) there's nothing wrong with this leg at all. It's the muscle in the back. The foot dead. (I was wondering what you could do). It's dead on the top here see. (hmm) numb.

40:04 therapist: but somehow on both legs the tendon down the outside has become a lot tighter than it should be.

40:07 still has one needle in ear

40:14 client: that's from not getting enough exercise I expect. [code – I'm getting old?]

40:19 therapist: I'm not sure if walking is doing it for you. (11 sec pause)

40:33 therapist: try and keep these thigh muscles working just by sitting in a chair and raising them.

40:41 client: that's what you told me about this, this before, didn't you? (have you been) I been doing it [client sounds somewhat frustrated that therapist giving same advice, which she forgot that she'd given before.]

40:47 therapist: have you been doing it? (yeah, yeah, yeah, yeah) (3 sec pause) Ok we'll have to think of something else.

40:52 still holding his knee

40:59 client: chop them off. (client laughs) Put wheels on.

41:06 therapist: okay well let's leave it. Let's take this last needle out, okay? (hmm mm)

41:08 last needle out

41:14 client: okay now?

41:15 therapist: yes, that's it. (7 sec pause)

41:23 therapist: have you ever had any, thank you. Have you ever had any advice about exercise?

41:28 client off couch

41:30 client: no (not really?) no. (hmm, okay)

41:34 starting to put clothes back on, therapist's taken paper cover off couch

41:36 therapist: well I'll do a bit of research and I'll see if I can find out what else might help to loosen up those tendons.

41:44 client: Like chickens as they get older their tendons get tougher. (both laugh) (14 sec pause)

42:10 client: they haven't fixed that plumbing yet then? (no) Well it don't sound so bad as last time though. [back to plumbing again. Already been mentioned.]

42:16 therapist: that's the noisiest bit. The radiator's (yeah). (4 sec pause) You can turn this tap off but look what happens. The tap actually moves it around. Anyway, they are getting on in the building, aren't they? (oh yeah, yeah)

42:30 therapist showing what's wrong with the tap

42:40 therapist writing notes while client in corner getting dressed

42:42 client: glad you got the lift set up though (yes). (23 sec pause)

43:07 therapist: how's that feeling, [client's name] at the moment?

43:10 client: pardon?

43:11 therapist: how's your hip feeling at the moment?

43:13 client: okay, okay. ----sore---- (6 sec pause).

43:30 therapist: I think if we leave it another month that will be in the middle of the Christmas holidays. (yeah) Do you want to come in three weeks?

43:40 client: whenever you want my dear. [seems to be implying that he's doing it for her.]

43:42 therapist: well we could do that. I think that would be *(turns pages of diary)* Actually it would have to be in 2 weeks. It's in two weeks or in five. What do you think? Would you like to get one in before Christmas? [when not looking at her diary, therapist seems to think seeing client in another month best, but then when no space arranges to see him in 2 weeks. Surely 5 weeks is closer to a month than 2. How much is this not because of his physical condition but b/c therapist is worried about him emotionally & Christmas coming up which may be hard for him. Is this appropriate use of funds? Interesting that in terms of this being a community project, I would say yes because social inclusion a big part of community projects. But if it were funded by the NIIS, I would think no b/c the NHS isn't about helping people feel happier at Christmas. So in my head it makes a difference who funds it.]

43:54 *therapist looking at her diary*

44:03 client: yes, please if I could.

44:05 therapist: the 14th. (15 sec pause)

44:22 therapist: I was just thinking if you can get over to [place name] then you can get over to my house and you could have a session with my infra red lamp, if you like.(pause) At some point if you think you could get over there [client doesn't sound all that keen. So can get over to this part of the city where therapist lives for his walk, but not for a treatment. Priorities?]

44:24 *client sitting down and putting on his socks, therapist offering session in private setting (need to think about how therapist switches between settings)*

44:41 client: it's the getting over there

44:43 therapist: I know.

44:48 client: I'd have to get a bus from here to the centre. And the centre up to [place name]. You're not too far from the [place name]?

44:57 therapist: I'm not too far from the [place name]. In fact I'm going to be working around the corner from the [place name] (are you?) at a clinic in [place name]. (oh) yes, just round the corner. Well that's something we could think about for the new year. 'cos I do think

45:22 client: well the nearest bus stop there would be, would be the [place name], wouldn't it? Because the bus stop, they come round the back of it now, don't they,

(that's right) instead of through (yeah) Where the post office used to be, where the post office delivery place used to be. But I don't know whether it is still there.

45:30 therapist wiping her hands

45:38 client putting on shoes

45:42 therapist: what, [name] street?

45:43 client: yes that's right. (11 sec pause)

45:57 therapist: I wrote it on the card for you. (12 sec pause)

46:05 therapist writing next appointment on card

46:10 client: they asked me if I could manage more than one game of snooker last week and I couldn't. I had a job to get round from one little hole to (3 sec pause) (client coughs) (34 sec pause) [a final "poor me" story]

46:34 client putting on coat, therapist tidying desk

46:54 therapist: okay, have you got everything?

46:56 client: yeah, I think so.

46:59: therapist: ---. *(client hands money over)* Thank you [client's name]. Next time I'm going to have to take more money off you because we're running out of funds and it's going up to 5, if that's okay.

47:00 signs and client giver her money straight away. He has it in his hands.

47:09 client: yeah, that's okay. No trouble at all. You can have 5 now if you want it.

47:12 therapist: no, no we'll make it later.

47:13 client: yes, go on.

47:17 therapist: okay, thank you. We're hoping to be able to keep the project open beyond April. But that's your next appointment. [big difference from previous client who gave therapist mixed messages]

47:27 client: all right, love. Give me three back now. (therapist laughs) Oh yeah, I know Christmas present for [therapist's daughter].

47:36 therapist: (both laughing) you spotted me.

47:37 client: give her my regards. [personal interchange again.]

47:38 therapist: will do, I know. Well you take care of yourself and I really hope things sort themselves out with you.

47:48 client: I'll try. Cheerio for now then, [therapist's name].

Interesting that therapist always walks down to get her clients and picks them up and shows them out. Great courtesy. Part of the private service culture that patients want? If so, takes place in community settings as well.

Appendix E Matched consultations

The table below compares the paired homeopathy consultations. The items in bold are those topics or activities that occurred in both settings; the items in italics are for sounds; the items underlined are my reactions. Unless otherwise noted, all of the topics were initiated by the therapist.

Table 14 Differences in matched homeopathy consultations identified in detailed analysis

Private setting		NHS setting	
00:00	Structure of session How homeopathy works	00:00	Current herbal treatment & past health history
1:00	Referral route	1:05	<i>Cough outside door</i>
1:30	Patient form filled in w/ details on address, doctor, marital status, children, current medication	2:00	Referral route
3:04	“So fire away”: reason for seeking treatment	3:00	Structure of session How homeopathy works
5:33	<i>Door opening in hallway</i>	4:30	Patient form filled in w/ details on address, doctor, marital status, children, current medication
5:53	Menopause history & symptoms	7:00	“what do you want help with?” Reason for seeking treatment – menopause symptoms
7:38	“Run me through a typical night from start to finish”	11:30	General health & health as a child
8:50	<u>LW sneezes</u>	12:14	<i>People in corridor talking</i>
10:33	Body temperature	14:03	<u>LW sneezes</u>
12:08	Client’s job	16:00	Food likes and dislikes
12:38	Dreams	18:00	Current general health

15:20	“what else?” general health	22:00	Current conventional medication use
19:42	“anything else?” mood swings	24:00	Current general health symptoms including bowel habits
21:30	Skin – therapist physically examines	26:00	<i>Music outside</i>
24:47	Menstrual history	27:14	Family health history
30:00	Contraceptive pill use	30:00	Body temperature
31:30	Health as a child	31:00	<i>Loud music in hall enough so patient raises her voice</i>
32:00	Food likes and dislikes	31:26	“Run me through a typical night”
35:00	What drinks & degree of thirst	33:15	Dreams
37:23	Bowels and bladder habits	36:00	Patient’s psychic ability
40:00	Fears or phobias	37:00	Patient’s job
44:00	“what sorts of things do you like?” “what do you do to relax?”	38:00	Fears or phobias
45:00	Client volunteers exercise habits	39:00	<i>Music outside</i>
46:33	Client volunteers information on holidays	42:00	“what do you enjoy doing?”
46:43	Asthma	43:12	“anything else?”
48:00	<i>Emergency vehicle siren outside</i>	44:33	Client regrets
49:01	Family health history	45:00	Pregnancies & contraceptive pill use
53:00	Allergy testing	47:00	Menstrual history
53:40	Remedy prescription folliculinum	49:26	<i>Noises in corridor</i>
54:15	MYMOP	50:00	MYMOP
54:20	Homeopath leaves room to get	51:39	How to combine homeopathy,

	remedy		herbal medication & conventional medication
59:26	Remedy instructions – 1 today & 1 tomorrow – Client ingests 1st tablet	53:39	What drinks & caffeine intake
60:00	How to contact therapist between appointments	55:15	Homeopath deciding on remedy out loud
61:01	Homeopath writes down remedy instructions	55:55	Homeopath gives patient homeopathy information sheet
62:00	Homeopath adds 'prescription' of 6 glasses of water a day	57:20	Remedy instructions written down – sepia 3 a week for 4 weeks – Patient ingests 1st tablet
64:00	When to re-book (4 weeks)	60:01	Patient volunteers history of acupuncture use
64:30	Client thanks homeopath	61:02	How to contact therapist between appointments
		62:00	When to re-book (3 weeks)
		64:00	Patient thanks therapist 3 times

Again similar activities occurring in the two settings are highlighted in bold for the comparison of acupuncture settings, although they may have occurred at different time points within the consultation process. The format of this table is purposely different from that of homeopathy as otherwise many of the details about the differences in the acupuncture consultations would have been lost.

Table 15 Differences in matched acupuncture consultations identified in detailed analysis

Private setting		NHS setting	
No consultation before or after		Last of 5 consultations	
Client's daughter present		Patient on her own	
"Party atmosphere"		More subdued	
First 2 ½ minutes small talk on holidays		No small talk	
Infra red light used to conduct heat into client's stomach via needles		No infra red light used	
Therapist twists needles once inserted		Therapist twists needles once inserted	
No scraping of stomach		Therapist scrapes client's stomach with fingernails	
Therapist starts notes a third of the way through the session.		Therapist takes notes from the beginning.	
7 episodes of healing silence* totalling 25:04 minutes, the majority after all needles removed, longest lasting 5:17		3 episodes of healing silence* totally 21:44, the majority while needles in place, longest lasting 13:21	
No application of healing energy using hands		Therapist sends healing energy through her hands to client's sinuses	
Minimal background noise		Minimal background noise	
Therapist leaves room twice		Therapist does not leave room	
4:29	Tongue diagnosis – once only	00:25 & 7:07	Tongue diagnosis – twice in total
5:17	Pulse taken before inserting 1 st needle	14:14	Pulse taken for the first time after 6 needles already inserted
10:00	Physical examination of	9:18	Physical examination of

	client's abdomen		patient's sinuses, no exam of abdomen
13:56	First needle inserted in abdomen	7:39	First needle inserted in abdomen
22:37	Last needle in abdomen	27:19	Last needle in abdomen
24:31	Moxa applied to draw heat into client's stomach	30:41	Moxa applied to draw heat into patient's stomach
38:26	<u>LW feels 1st energetic shift</u>	33:55	<u>LW feels 1" energetic shift</u>
47:41	Therapist leaves room to wash hands	27:33	Therapist washes hands in room
47:41	Patient falls silent	30:41	Patient falls silent
60:02	All needles out	49:14	All needles out
67:15	Client rebooks for 2 weeks' time	53:07	Client rebooks for 2 weeks' time
68:28	Client pays	53:58	Patient pays
68:39	Client initiates hug	-----	No hugs
69:04	Consultation finished	55:03	Consultation finished

* healing silence is defined as two minutes or more after all needles are inserted when both the client and the therapist are quiet.

Appendix F Evaluations of complementary therapy services

Benson K. (March 2004) Complementary health offered in the community for everyone (C.H.O.I.C.E) Evaluation Report. Lewisham. – **CHOICE service**

Budd C, Fisher B, Parrinder & Price L. (1990) A model of cooperation between complementary and allopathic medicine in a primary care setting. *British Journal of General Practice* 40, 376-378. – **Wells Park service**

Burns K & Lyttelton L. (1994) Osteopathy on the NHS: one practice's experience. *Complementary Therapies in Medicine* 2, 200-203. – **Leyton Green service**

Chaplin S. (2005) Chips annual report 2004-2005. available from www.ndcbristol.co.uk/ - **CHIPS service**

Christie E & Ward. (September 1996) A report on NHS practice based homeopathy project: Analysis of effectiveness and cost of homeopathic treatment within a GP practice at St. Margaret's Surgery. The Society of Homeopaths. – **St. Margaret's service**

Day A & Kingsbury-Smith R. (2004) An audit of acupuncture in general practice. *Acupuncture in Medicine* 22, 87-92. – **Day & Kingsbury Smith service**

Dempster A. (September 1998) Homeopathy within the NHS: Evaluation of homeopathic treatment of common mental health problems. The Society of Homeopaths. – **Bounds Green service**

Dixon M. (1998) Does 'healing' benefit patients with chronic symptoms? A quasi-randomized trial in general practice. *J of the Royal Soc of Medicine* 91, 183-188. – **Cullompton service**

Freedman J. (2002) An audit of 500 acupuncture patients in general practice. *Acupuncture in Medicine*. 20, 30-40. – **Freedman service**

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Joesph P. (2002) A survey of acupuncture treatments in general practice. *Acupuncture in Medicine* 20, 100-1. – **Joseph service**

Joire D. (2001) Gateway clinic service evaluation. – **Gateway service**

Kelly S. (2005) Untitled report. Available from Fiona Robertson at info@impact-imp.co.uk. - **Impact service**

King Anna with Sarah del Tufo. (2002) A collaborative evaluation of the Complementary Health's Initiative's Pendeen Complementary Health Initiative Pilot. The Evaluation Trust, Pendeen. – **CHI service**

Monk J & Chaplin S. (2002) CHIPS Evaluation Report – update. Available from www.ndcbristol.co.uk. - **CHIPS service**

Mulkins A, Verhoef M, Eng J, Findlay B & Ramsum D. (2003) Evaluation of the Tzu Chi Institute for Complementary and Alternative Medicine's Integrative Care Program. *Journal of Alternative & Complementary Medicine*. 9, 585-592. – **Tzu Chi service**

Nichol J, Gabriel S & Prior C. (2004) CHIPS Action Research: Initial analysis of interviews and focus groups conducted between 23 September 2003 and 3 March 2004. – **CHIPS service**

Peters D, Andrews H & Hills D. (2005) Integrating complementary medicine into primary care – an audit of five month referrals to the Get Well UK complementary therapy services in South Islington. Available from www.getwelluk.com. - **Get Well UK service**

Relton C & Weatherley Jones E. (2005) Homeopathy service in a National Health Service community menopause clinic. *Journal of the British Menopause Society* 11, 72-73. – **Sheffield service**

Reason P. (1991) Power and conflict in multidisciplinary collaboration. *Complementary Medical Research* 5, 144-150. – **Marylebone service**

Reason P. (1995) Complementary practice at Phoenix Surgery: first steps in cooperative inquiry. *Complementary Therapies in Medicine* 3, 37-41. – **Phoenix service**

Richardson J. (1999) Assessing the Impact of Complementary Therapy on Health Status. Unpublished thesis number 215122. King's College, University of London, London. – **Lewisham service**

Richardson, J. (2001) Developing and evaluating complementary therapy services: part 2. Examining the effects of treatment on health status. *Journal of Alternative and Complementary Medicine* 7, 315-328. – **Lewisham service**

Ritchie J, Wilkinson J, Gantley M, Feder G, Carter Y & Formby J. (2001) A Model of Integrated Primary Care: Anthroposophic Medicine. National Centre for Social Research. Department of General Practice and Primary Care. Queen Mary, University of London. – **Anthroposophical**

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Solomon D. (2003) Complementary Therapy Pilot. Newcastle Primary Care Trust & Newcastle West Gate New Deal for Communities, Newcastle. Available from Dawn.Solomon@newcastle-pct.nhs.uk. - **Newcastle service**

Stellon A. (2001) An audit of acupuncture in a single handed general practice over one year. *Acupuncture in Medicine* 19, 36-42. – **Stellon service**

Thomas, K & Harper R. (1999) GP-based purchasing of osteopathy and chiropractic; an evaluation of a Pilot Scheme 1996-1998. MRC Unit. School for Health and Related Policy, University of Sheffield. – **GP purchasing service**

Thomas K, Strong P. & Luff D. (2001) Complementary Medicine service in a community clinic for patients with symptoms associated with the menopause: outcome study & service evaluation. MRC Unit. School for Health and Related Policy, University of Sheffield. – **Sheffield service**

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Unwin J. (2006) Gatekeepers and the Gateway. Unpublished MSc thesis. University of Westminster, London. – **Gateway service**

Walters C & Batty J. (2003) North Kirklees PCT Homeopathy Service Pilot Project. – **North Kirklees service**

West Yorkshire Health Authority (1996) Introducing independent complementary therapists into GP practices in Huddersfield and Dewsbury. West Yorkshire Health Authority. – **West Yorkshire service**

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Williams N, Edwards R, Linck P, Muntz R, Hibbs R, Wilkinson C, Russell I, Russell D & Hounscome B. (2004) Cost utility analysis of osteopathy in primary care: results from

a pragmatic randomized controlled trial. *Family Practice* 21, 643-650. – **ROMANS service**

Appendix G SF36 and MYMOP tables from service evaluations

Table 16 SF36 health outcome data from six complementary therapy service evaluations

SF36 aspect	Evaluation	N	Difference (SD)	95% CI
Physical functioning	Impact	54*	7.1 (16.6)	2.7 to 11.5
	Tzu Chi	212	4.9	-----
	Glastonbury	224*	4.8	-----
	Lewisham	179*	3.4	0.6 to 6.1
	Liverpool	69*	3	-1.8 to 7.6
	GP purchasing	312	5.9 (19.48)	2.3 to 9.5
Role physical	Impact	54*	26.4 (44.1)	14.6 to 38.2
	Tzu Chi	210	6.7	-----
	Glastonbury	224*	17.4	-----
	Lewisham	179*	22.4	15 to 29.9
	Liverpool	69*	9	0.2 to 18.3
	GP purchasing	311	27.06 (47.42)	21.8 to 32.3
Role emotional	Impact	54*	20.9 (47.9)	8.1 to 33.7
	Tzu Chi	210	8.6	-----
	Glastonbury	224*	11.5	-----
	Lewisham	179*	15.1	4.7 to 24.6
	Liverpool	69*	7	-4.1 to 17.4
	GP purchasing	308	9.0 (43.3)	4.2 to 13.9
Social functioning	Impact	54*	12.7 (32.8)	4.0 to 21.5
	Tzu Chi	211	12.9	-----
	Glastonbury	224*	-----	-----
	Lewisham	179*	12.8	7.1 to 18.5

	Liverpool	69*	7	1.2 to 13.9
	GP purchasing	321	12.05 (27.2)	9.1 to 15
Pain	Impact	54*	27.2 (28.3)	19.7 to 34.7
	Tzu Chi	207	6.4	-----
	Glastonbury	224*	-----	-----
	Lewisham	179*	12.9	8.4 to 17.4
	Liverpool	69*	7	3.3 to 12.9
	GP purchasing	320	23.8 (26.9)	20.8 to 26.7
Vitality	Impact	54*	11.1 (22.7)	8 to 14.2
	Tzu Chi	211	6.5	-----
	Glastonbury	224*	-----	-----
	Lewisham	179*	8.6	4.7 to 12.5
	Liverpool	69*	6	0.6 to 10.4
	GP purchasing	315	8.5 (19.08)	6.4 to 10.7
Mental health	Impact	54*	10.2 (20.4)	4.8 to 15.6
	Tzu Chi	211	7.5	-----
	Glastonbury	224*	-----	-----
	Lewisham	179*	5.9	2.3 to 9.4
	Liverpool	69*	5	-0.1 to 9.3
	GP purchasing	317	5.3 (16.7)	3.5 to 7.1
General health	Impact	54*	8.9 (21.6)	3.1 to 14.7
	Tzu Chi	212	5.7	-----
	Glastonbury	224*	-----	-----
	Lewisham	179*	5.5	2.3 to 8.7
	Liverpool	69*	1	-2.3 to 6.1
	GP purchasing	308	8.5 (19.1)	6.4 to 10.7

Table 17 MYMOP health outcome data from five complementary therapy service evaluations

MYMOP aspect	Evaluation	N	Difference (SD) Pre & post	95% CI
1st symptom	Coventry	80	2.5	2.1 to 2.9
	CHIPs	67	1.9 (1.8)	1.5 to 2.3
	N Kirklees	65	2.3	1.9 to 2.8
	Impact	85*	2.6 (1.7)	2.3 to 3.0
	Sheffield	54	2.3 (1.9)	1.8 to 2.8
2nd symptom	Coventry	55	2.5	2.0 to 3.0
	CHIPs	49	1.4 (2.0)	0.9 to 2.0
	N Kirklees	-----	-----	-----
	Impact	85*	2.4 (1.5)	1.9 to 2.9
	Sheffield	53	2 (2.0)	1.5 to 2.5
Activity	Coventry	63	2.4	2.0 to 2.9
	CHIPs	54	1.3 (2.0)	0.9 to 1.9
	N Kirklees	----	-----	-----
	Impact	85*	2.0 (1.6)	1.5 to 2.4
	Sheffield	29	1.9 (1.7)	-0.4 to 4.2
Wellbeing	Coventry	66	1.4	1.0 to 1.8
	CHIPs	67	1.3 (2.0)	0.8 to 1.8
	N Kirklees	65	1.6	1.2 to 2.0
	Impact	85*	1.7 (1.6)	1.3 to 2.1
	Sheffield	39	1.6 (1.9)	1.0 to 2.2
Profile	Coventry	-----	-----	-----
	CHIPs	67	1.5 (1.4)	1.1 to 1.8
	N Kirklees	----	-----	-----
	Impact	----	-----	-----
	Sheffield	29	2.1 (1.6)	1.5 to 2.7
	Get Well UK	44	1.5 (1.3)	1.1 to 1.9

Appendix H Results from Lewisham and ROMANS trials

Table 18 SF36 results from Lewisham complementary therapy service trial

Scale	Control mean (SD)	Treatment mean (SD)	Mean difference	95% Confidence interval
Physical functioning	50.3 (29.9)	56.4 (32.5)	6.0	-1.0 to 13.1
Role physical	23.5 (35.4)	43.4 (42.3)	19.9	11.2 to 28.6
Pain	37.8 (26.8)	52.7 (29.7)	14.9	8.5 to 21.2
General health	40.6 (22.9)	51.4 (24.2)	10.8	5.5 to 16
Vitality	31.1 (21.4)	43.7 (22.1)	12.2	7.7 to 17.6
Social functioning	47.3 (32.1)	63 (31.6)	15.7	8.4 to 22.9
Role emotional	38.8 (42.8)	59.5 (43.5)	20.7	11 to 30.3
Mental health	51.5 (23.9)	60.8 (21.8)	9.3	4.1 to 14.4

Table 19 Results from ROMANS trial - scores at 2 months

Outcome measures	Usual care mean change	Osteopathy mean change	Difference	95% Confidence intervals
EASPS	8.6 (14.2) n=67	13.9 (12.8) n=69	5.3	0.7 to 9.8
SF 12 physical	4.1 (8.6) n=68	5.4 (8.9) n=65	1.3	-1.7 to 4.3
SF12 mental	1.2 (12) n=68	7.9 (11.2) n=65	6.7	2.7 to 10.7
SMPQ total	2.1 (7) n=67	4.6 (8.0), n=70	2.5	-0.1 to 5.0
SMPQ sensory	1.6 (5.9) n=67	3.5 (6.3) n=70	1.8	-0.2 to 3.9
SMPQ affective	0.5 (2.0) n=67	1.1 (2.6) n=70	0.6	-0.2 to 1.4
SMPQ VAS	6.8 (23.4) n=68	14.4 (24.7) n=70	7.6	-0.4 to 15.8
SMPQ 0-5	0.4 (1.2) n=68	0.7 (1.2) n=70	0.3	-0.1 to 0.7
EQ 5D	0.06 (0.29) n=65	0.11 (0.28) n=66	0.006	-0.04 to 0.15
EQ 5D therm	4.8 (20.9) n=64	10.6 (22.6) n=64	5.8	-1.8 to 13.5

Table 20 Results from ROMANS trial - scores at 6 months

Outcome measures	Usual care mean change	Osteopathy mean change	Difference	95% Confidence intervals
EASPS	10.4 (18.) n=68	14.9 (16.1) n=62	4.4	-1.5 to 10.4
SF 12 physical	5.5 (9.4) n=64	7.4 (10.3) n=57	1.9	-1.6 to 5.4
SF12 mental	1.4 (11.3) n=64	6.8 (13.6) n=57	5.5	1.0 to 9.9
SMPQ total	3.7 (8.1) n=69	6.6 (8.8) n=61	2.9	-0.05 to 5.8
SMPQ sensory	3.0 (6.6) n=69	4.8 (6.8) n=61	1.8	-0.55 to 4.1
SMPQ affective	0.7 (2.7) n=69	1.8 (2.8) n=61	1.1	-0.1 to 2.1
SMPQ VAS	10.1 (24.1) n=68	15.7 (27.3) n=61	5.5	-3.4 to 14.4
SMPQ 0-5	0.6 (1.1) n=69	0.9 (1.1) n=62	0.3	-0.06 to 0.7
EQ 5D	0.10 (0.28) n=66	0.10 (0.30) n=57	0	-0.1 to 0.1
EQ 5D therm	5.1 (20.7) n=65	10.2 (24.9) n=58	5.1	-3.1 to 13.2

Appendix I Allocations of time in acupuncture consultations across 3 settings

Table 21 Detailed analysis of time in NHS acupuncture consultations

Observation number	Patient number	Intended consultation time	Actual consultation time	Needling time	Number of procedures	Length of healing silences	Number of healing silences
1	1	50 minutes	41:48	27:50	1	0	0
4+	2	50 minutes	46:40	20:38	3	5:47	2
5+	3	50 minutes	50:59	17:03	1	Not recorded	Not recorded
6	4	50 minutes	42:00	Not recorded	Not recorded	Not recorded	Not recorded
7*	5	50 minutes	44:23	27:27	1	5:50	1
8	6	50 minutes	47:48	31:41	2	11:16	3
9	7	50 minutes	50:38	35:00	3	14:34	2
10	4	50 minutes	51:29	26:07	1	Not analysed	Not analysed
14	8	50 minutes	55:03	41:35	2	21:44	3
Average	-	50 minutes	47:45	28:25	1.4	11:50	1.7

+ Initial consultations * technical difficulties so several minutes of this consultation not recorded

Table 22 Detailed analysis of time in private home acupuncture consultations

Observation number	Patient number	Intended consultation time	Actual consultation time	Needling time	Number of procedures	Length of healing silences	Number of healing silences
11	8	60 minutes	69:04	46:06	2	25:04	7
12	9	60 minutes	72:00	55:02	4	29:23	6
13	10	60 minutes	62:33	47:01	1	33:09	4
Average	-	60 minutes	67:52	49:23	2.3	29:12	5.6

Table 23 Detailed analysis of time in private clinic acupuncture consultations

Observation number	Patient number	Intended consultation time	Actual consultation time	Needling time	Number of procedures	Length of healing silences	Number of healing silences
2	2	45 minutes	49:00	25:11	2	0	0
3	1	45 minutes	46:27	25:40	1	6:42	2
Average	-	45 minutes	47:44	25:42	1.5	3:21	1

Appendix J Glossary

BMA	British Medical Association – professional body of doctors practising in Great Britain
Cupping	“Cupping refers to an ancient Chinese practice in which a cup is applied to the skin and the pressure in the cup is reduced (by using change in heat or by suctioning out air), so that the skin and superficial muscle layer is drawn into and held in the cup.... Today, cupping is mainly recommended for the treatment of pain, gastro-intestinal disorders, lung diseases (especially chronic cough and asthma), and paralysis, though it can be used for other disorders as well.” Taken from: www.itmonline.org/arts/cupping.htm (accessed 3.4.07)
Family Health Services Authority	FHSA – local commissioning bodies for primary care from the early 1990s until the advent of Health Authorities.
Family Practitioner Committees	FPCs – Precursors to Family Health Services Authority (see above)
Foundation for Integrated Health	Previously known as the Foundation for Integrated Medicine and the Prince of Wales’s Foundation for Integrated Health, this small organisation was established by the Prince of Wales in the mid-1990’s to promote the integration of biomedicine and complementary therapies.
Fund-holding	Initiative in the 1990s in which local GPs were allowed to keep “practice savings” to invest in new ways of delivering services. Resulted in expansion of complementary therapy services. Discontinued towards the end of the 1990s, but the principles have been re-introduced with the advent recently of practice based commissioning.
Group 1 therapies	These include osteopathy, chiropractic, homeopathy, herbal

	medicine and acupuncture. Also known as the 'Big 5', these were the therapies identified by the Select Committee of the House of Lords as most likely to become available on the NIS.
Health authority	Local organisational bodies formed in the 1990s that commissioned primary and secondary care services until replaced by Primary Care Organisations (including Primary Care Groups and PCTs – see below).
Health commissioners	Another name for PCT managers (see below)
Kinesiology	Energy based complementary therapy that uses muscle testing as a diagnostic tool and “borrows” from a variety of traditions to affect treatment such as acupressure, homeopathy, essential oils and nutrition.
Moxa	Moxa is a herbal preparation of mugwort that is lit and then either applied directly to the skin or circled slowly round the needles. The process is called moxibustion and is used to increase the amount of heat going into the body.
NICE	National Institute for Health and Clinical Effectiveness – established with the aim of being an independent agency, the role of NICE is to review treatments, primarily of a pharmacological nature, and publish guidance on their adoption within the NHS. In theory, if NICE dictates that a particular intervention is effective and cost effective, PCTs are obligated to provide them locally. See www.nice.org.uk .
Primary Care Organisation	PCO – the collective name for Primary Care Trusts and Primary Care Groups, the latter of which were the precursors to Primary Care Trusts
PCT	Primary Care Trust – organisational bodies that commission primary and secondary care services, manage the devolved budget from the Department of Health, evolved from Health Authorities and came into existence in 2002.

PEC	Professional Executive Committee – A sub-committee of the PCT made up of the Chief Executive, a chair, senior directors and representatives from local doctors, nurses and practice managers. The aim of the PEC is to review services currently commissioned and consider gaps in service provision.
Practice based commissioning	Established in 2006 and still in its infancy, the aim of practice based commissioning was to devolve decision-making to frontline clinicians, principally GPs. To do this, groups of GP surgeries are banded together to create consortia. In practice however, PCTs still hold the majority of the commissioning power.
Quality outcome frameworks	Quality and Outcome Frameworks (QOF) is a system for incentivising GPs to carry out certain functions within their practice populations. With the successful implementation of each function, QOF points are awarded. The more points that are awarded, the more remuneration the practice receives. In practice, during consultations a ‘pop up’ will appear on the clinicians’ computer screen reminding him or her to take the patient’s blood pressure or book the patient for a smear test, for example. If these tasks take place, points are awarded.
TAT	Made up acronym for the community based organisation set up to administer funds won through the New Deal for Communities initiative at case site 1

Appendix K Themes, categories and codes

The table below identifies the specific codes associated with the fourteen themes discussed in the main body of the thesis. Some codes are linked to more than one theme. In some cases, codes were grouped into categories and then themes.

Table 24 Themes, categories and codes

Theme	Category	Code
Paradigmatic tensions		Differences in medical/CAM approaches Reductionism Paradigmatic tensions
Rhetoric on evidence based medicine		Decision making Role of evidence Add on or instead of Patient choice Political/ economic pressures
'Reality' of evidence available	Evaluations Systematic reviews	Health status – SF36 Health status - MYMOP NHS cost pressures Trial data Acupuncture evidence Homeopathy evidence
Discrepancies between rhetoric and reality		Role of evidence Decision making Evidence – access to Evidence hearsay Herbal medicine evidence & provision Spinal manipulation evidence & provision Counselling evidence

Theme	Category	Code
Factors that did not influence service design, delivery or survival	Attitudes	Attitudes of NHS professionals to CAM NHS professionals' attitudes to service Service impact on doctor attitudes
	Experience	Difference service makes Personal use and knowledge of CAM
Structural factors influencing service design, delivery & survival	Specific therapies for specific conditions	Therapeutic niche Safety Role of evidence
	Service features	Research and evaluation of service Demand management mechanisms Patients – who should access service Funding Clinic location Service – publicising of
	High priority	Unmet need Add on or instead of Patients – who should access service Political/ economic pressures Impact on NHS services

Theme	Category	Code
Process factors influencing service design, delivery & survival		Relationships Advocates Leadership Patient centred care Patient choice
Patient characteristics		Patient socio-economic characteristics Patient conditions
Similarities in settings in private and NHS settings		Role of therapist Patient preferences - settings Clinical practice differences 'Typical' consultation
Differences in private and NHS settings	Therapist noted	Clinical practice differences Patient differences Role of therapist Organisational constraints Equipment
Differences in settings (continued)	Patient noted Researcher noted	Patient preferences – settings Consultation length Consultation number Disrobing Role of therapist Paperwork Procedures
Differences expected but not found		Charging Funding

Theme	Category	Code
Space and time	Space	Premises
		Room allocation
		Clinic location
	Time	Consultation length
		Consultation number
		Procedures
		Silence
		Rest

Appendix L Published paper



Evaluating complementary and alternative therapy services in primary and community care settings: A review of 25 service evaluations[☆]

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Available online 24 January 2006

Summary

Objectives:

- (1) To review evaluations of primary and community care complementary therapy services.
- (2) To explore the impact evaluation reports may have had on funding decisions taken by NHS commissioners.

Design: We collected 32 reports for 25 services, principally in England. Reports were analysed for content using the structure-process-outcome model. Modified BEST-CAM guidelines, which came out of a Delphi consensus exercise rating the ability of reports to address commissioners' priorities, were used to address the second objective.

Results: Most commonly, evaluators carried out data extraction of referral forms (10), costings of the service (9), patient satisfaction questionnaires (9) and patient health status questionnaires (8). Five service evaluations addressed NHS cost pressures, with another carrying out a cost effectiveness assessment with QALY.

Conclusion: Addressing commissioners' priorities (e.g. GP consultations rates, prescription rates, secondary care referrals) in complementary therapy service evaluations may bolster chances of securing funding, but are unlikely to be enough on their own.

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Introduction

Evaluating complementary therapy services is challenging, especially for non-researchers. NHS funding bodies sometimes predicate further funding of complementary services on the production of an evaluation. In response to simultaneous requests from the Prince of Wales's Foundation for Integrated Health, who wanted an update of earlier work,¹ and Complementary Health in Partnerships (CHIPS), a complementary therapy service who were designing their own evaluation, we decided to carry out a review to learn more about how others approached this rather daunting task.

Early on we discovered the fallacy of an inherent assumption—that positive evaluations lead to further funding of a service. We learnt that many relatively robust evaluations of complementary therapy services demonstrating major health benefits did not lead to further commissioning of the services. Were there other factors at work? If good patient outcomes were not enough to persuade commissioners, what would?

In publishing this study, we hope to help our target audience of NHS complementary therapists facing their first evaluation. Our aims are two-fold: firstly, to describe the approaches others have used and secondly to unpick the relationship between evaluations and funding decisions so that more evaluations are successful in providing useful information for commissioners.

We have many predecessors in grappling with the complexities of evaluating complementary therapy services. In a report now over a decade old, the Liverpool Public Health Observatory recommended that cost-effectiveness measures, validated health outcomes tools and patient views be included.² In later work, Rees critiqued three complementary therapy service evaluations and argues that clear evaluation goals, an appraisal of objectives, recommendations for action and rigorously applied, robust methods are necessary.³ More recently, Thomas suggested that the first step is clarifying the right questions before choosing an appropriate methodology.⁴

The scope of our enquiry included a range of issues including:

- the kind of outcomes studied;
- study approach (e.g. quantitative or qualitative/external or internal evaluators/structure, process or outcome focused/sources of data such as medical records, surveys, etc.);
- report layout and authorship.

This breadth of review was essential in teasing out the extent to which any or all of the above might play a part in positive funding decisions. This study does not attempt to establish effectiveness, rather we explore the impact evaluations may have had on funding decisions.

Methods

Document collection

To do this, we collected reports from November 2003 to July 2005. As many of the evaluations of complementary therapy services are 'grey literature' and therefore not easily found in database searches, a rigorous, comprehensive searching strategy was devised including:

- Contacting colleagues at the Foundation for Integrated Health, mid-Devon Primary Care Research Group and the Universities of Bristol, Sheffield, Thames Valley and Westminster as they had conducted studies themselves and/or were well networked to identify others who had.
- Contacting all members of the primary and secondary wave collaboratives of the Foundation for Integrated Health, many of whom had conducted or commissioned an evaluation.
- Searching PubCAM sub-database of Medline.
- Identifying potential studies from bibliographies of reports previously collected.
- Hand searching issues of *Complementary Therapies in Medicine*, *Homeopathy*, *Journal of Alternative and Complementary Medicine*.
- Telephoning professional bodies.

Papers and reports were included if the service was delivered in state funded primary or community care (with one exception) and located in the UK (with one exception). The two exceptions (Lewisham²³⁻²⁵ and Tzu Chi¹⁹) were included because both evaluations were carried out with the explicit aim of winning state funding for their primary care complementary therapy services. Without them a review of evaluations would be incomplete. Documents were excluded if they reported throughput alone (e.g. numbers of patients seen), described solely the setting up of the service, were "discussion papers" or were evaluations of treatments paid for privately or delivered in secondary care or charities. Most projects had only one report, but three had two and two had three. In total, 25 services were evaluated in 32 reports.⁵⁻³⁶

Identifying methods used in evaluation reports

In setting out an analysis framework, the structure-process-outcome model often applied in health service evaluations was used.³⁷ These terms are defined as:

- structure—conditions under which care is provided, e.g. material resources, human resources, organizational characteristics, performance review and methods of paying;
- process—activities that constitute healthcare, e.g. referral criteria, diagnosis, treatment, rehabilitation and patient education;
- outcome—changes in individuals and populations that can be attributed to healthcare including health status, changes in knowledge or behaviour and patient satisfaction.

In applying this model, for each evaluation we first noted details such as date(s) of report, approach used (e.g. qualitative or quantitative) and position of evaluators (e.g. internal or external). We then identified sources of information (e.g. medical records, focus groups) with details collected from each source (e.g. prescription rates, patient satisfaction). Each source of information and subsequent details were classified as structure, process or outcome data. This gave valuable information on whether the evaluators focused on structure, process, outcomes or some combination of the three in constructing their study. We then amalgamated information from all of the reports to find the most common sources of information.

Identifying criteria to assess the ability of the reports to address state health funding priorities

Extracting these data was useful in clarifying the content of the reports, but did not assess if the reports addressed the concerns of state healthcare funders. For that another framework was needed. In early 2004, Wilkinson and colleagues carried out a Delphi exercise with academics, practitioners and professionals involved in NHS complementary therapy services in the UK.³⁸ The purpose was to identify key report criteria that would be of most interest to NHS commissioners (known as BESTCAM reports) (Table 1). A modified version of these criteria was applied in which duplicated criteria were deleted and two criteria were added ('acceptability to therapists' and 'clear objectives for evaluation'). As a crude measure, each report was assessed in light of these 27 criteria and given a score.

Table 1 (Modified) Guidelines for developing Broad Evidence Synthesis Topic for Complementary and Alternative Medicine Reports (BESTCAM reports)

1. Structure and format for BEST CAM reports
1.1. Rigorous (clear methodology for evaluating the evidence)
1.2. The basis for evidence collection kept simple, accessible and practical for users
1.3. Summary and conclusions easily available to patients, practitioners and physician
1.4. The context/rationale should be stated from the outset (see point 4 'drivers for CAM' ^a)
2. Contents
2.1. Introduction
2.2. Reference section
2.3. Summary of findings
2.4. Conclusion section
3. Priorities for reports
3.1. Conditions/conventional treatments with high cost implications in terms of NHS healthcare and other (e.g. social care) resources and absenteeism
3.2. Conditions that relate to the drivers for CAM (e.g. Local and National priorities) ^a
4. Priority topics to address in the reports
4.1. Potential for cost effective CAM interventions
4.2. Equity of care
4.3. Quality of service
5. The type of evidence collated should include
5.1. Impact on prescribing rate
5.2. Impact on secondary care referrals
5.3. Impact on GP consultation rates, workload and accessibility
5.4. Impact on other primary care services
5.5. Cost effectiveness, cost benefits and cost neutrality
5.6. Safety (including adverse events/incidents)
5.7. Health outcomes
5.8. Wider Health outcomes such as quality of life, wellbeing, etc.
5.9. Patient experience
5.10. Patient satisfaction
5.11. Acceptability to patients
5.12. Acceptability to GPs
6. Added criteria
6.1. Acceptability to therapists
6.2. Clear evaluation objectives

^a Drivers for CAM are considered to be local and national priorities, such as NSF's, waiting lists for conditions with a high local prevalence rate, Demand management, perceived effectiveness gap within conventional medicine, cost effectiveness, patient choice/access, patient safety, unmet or poorly met patient needs, service redesign or shift of resources, etc.

Table 2 Details of report methodologies

Name of service (BESTCAM ^a)	Year of report	External or internal	Structure-process outcome ^b	Approach	Data collection methods	Original funding ^c	Evaluation linked to funding ^d	Currently funded
Glastonbury (25)	1998 and 2003	Both	S-P-O	Mixed methods	Interviews of users, therapists and NHS staff/survey of users (pre-post health status) and pt satisfaction/data extraction from medical records (pre-post treatment) and referrals/validated health outcomes tools/costings of service and savings made	Health authority	Yes	Yes
Newcastle (21)	2003	Both	S-P-O	Quantitative	Survey of users (pt satisfaction)/data extraction of medical records (pre-post treatment) and referrals/validated health outcomes tools/costings of service and savings made	Primary Care Trust & New Deal for Communities	Yes	Yes
West Yorkshire (18)	1996	Not known	S-P-O	Quantitative	Surveys of GPs, therapists and users (pt satisfaction)/data extraction from referrals/validated health outcomes tool/costings of service	Health authority	Not known	No
North Kirklees (17)	2003	Internal	S-P-O	Quantitative	Surveys of GPs and users (pt satisfaction)/data extraction from referrals/validated health outcomes tools/case studies/costing of service	Primary Care Trust	Yes	No
Liverpool (16)	1995	External	S-P-O	Quantitative	Survey of GPs/data extraction from referrals/validated health outcomes tools/case study	Health authority	No	Yes
Sheffield NHS Menopause Clinic (16)	2001	External	S-P-O	Mixed methods	Interviews with therapists and GP/postal survey of users (health status)/data extraction of referrals and case notes/validated health outcomes tools/costing of service	Health Authority	Contributing	Yes
Complementary Health Initiative (16)	2002	External	P-O	Mixed methods	Focus group with NHS staff/telephone interviews with therapists/survey of users (health status)	New Deal for Communities	No	Yes

Table 2 (Continued)

Name of service (BESTCAM ^a)	Year of report	External or internal	Structure-process outcome ^b	Approach	Data collection methods	Original funding ^c	Evaluation linked to funding ^d	Currently funded
Complementary Health in Partnership (16)	2002 and 2004	Both	S-P	Mixed methods	Action research which included interviews with therapists, users and NHS staff/surveys of NHS staff and therapists/data extraction of referrals and pt monitoring form (pre-post health status)/case study/costing of service	New Deal for Communities	Contributing	Yes
Helios (15)	2001	Both	S-P-O	Mixed methods	Interviews with users, NHS staff and therapists/data extraction of medical records/validated health outcomes tools	Practice	No	Yes
GP based Purchasing (15)	1999	External	S-P-O	Mixed methods	Surveys of GPs and therapists/data extraction of referrals/survey users (patient satisfaction and health status)	Fundholding	Not Known	No
Get Well UK (14)	2005	External	S-P-O	Mixed methods	Data extraction referral form and patient monitoring form/Validated health outcomes tools/Practitioner evaluation form	New Deal for Communities	No	Yes
St. Margarets (14)	1996	Internal	O	Quantitative	Surveys of users (pt satisfaction)/data extraction of medical records/case studies/costings of service and savings made	Health authority	Yes	Yes
Tzu Chi (14)	2003	Internal	S-P-O	Mixed methods	Focus group of users/survey of users (pt satisfaction)/validated health outcomes tools	State~	Yes	No
Rydings Hall (14)	1998	Internal	P-O	Quantitative	Survey of users (health status)/costings of service and savings made	Fundholding	Not known	No
Lewisham (13)	1999	Internal	S-P-O	Quantitative (trial)	Validated health outcomes tools	Health authority	Yes	No
Coventry (13)	2004	External	S-O	Mixed methods	Data extraction of medical records/Validated health outcomes tools/Service evaluation questionnaire	Primary Care Trust	No	No

Bounds Green (12)	1999	Internal	S-P-O	Quantitative	Data extraction of case notes/costs of service and savings made	Fundholding	Contributing	No
Leyton Green (11)	1994	Internal	S-P-O	Quantitative	Survey of users (pt satisfaction and health status)/data extraction of case notes and medical records (pre-post treatment)	Family Health Service Authority Practice	Contributing	Not known
Cullompton (11)	1998	Internal	O	Quantitative (trial)	Data extraction of medical records/survey of users (pre-post health status)/validated health outcomes tools		No	Yes
ROMANS (11)	2003–2004	Both	O	Quantitative (trial)	Validated health outcomes tools	NHS	Contributing	Yes
CHOICE (10)	2004	External	S-P	Qualitative	Focus group users/Interviews with users, therapists, GP, project staff	New Deal for Communities	No	Yes
Hartcliffe and Withywood (9)	2003	Internal	S-P	Quantitative	Survey of users (pt satisfaction)	Single Regeneration Budget	No	No
Sydenham (9)	1990	Internal	S-P	Quantitative	Data extraction of referrals	NHS charitable trust	No	Not known
Phoenix (9)	1995	External	P	Qualitative (co-op inquiry)	Focus group with NHS staff and therapists	Not known	No	Not known
Marylebone (8)	1991	External	S-P	Qualitative (co-op inquiry)	Focus group with NHS staff and therapist	Not known	Not known	Yes

^a Evaluations ordered according to BESTCAM score.
^b S-P-O—structure, process and outcome information provided. P-O—process and outcome information only provided. O—outcome only information provided. S-P—structure and process information provided. S-O—structure and outcome information only provided.
^c New Deal for Communities and Single Regeneration Budgets—streams of regeneration funding for more disadvantaged communities generated from the Office of the Deputy Prime Minister. Family Health Service Authority, Health Authority and Primary Care Trust—all types of NHS commissioning bodies from 1990s to present day. “Practice” and “fundholding” — funding generated from the GP surgery themselves through practice savings. State~ = Canadian state funded project but unclear which funding stream.
^d Contributing—contributing to strategy to request further funding from NHS but decision of service based more on other criteria.

Ascertaining the relationship between the evaluation and further funding

All of the reports were coded as to the current funding status of the project and the role of the evaluation in securing any further funding. This information was obtained through personal contact with service evaluators or providers or from the reports themselves.

Results

General description of reports

Table 2 provides an overview of the 25 service evaluations reviewed. Five of the services first had evaluations published in 1995 or before, eight between 1996 and 2000 and 12 since 2001. Internal practitioners evaluated 11 services; external professionals evaluated eight; five were evaluated by both, and for one this information is not reported. In creating a typology there were:

- 12 research reports;
- 12 published papers;
- 7 reports tailor made for NHS commissioners;
- 1 Ph.D. thesis.

All of the reports were broadly positive, usually demonstrating patient satisfaction as well as NHS staff satisfaction in addition to including favourable data on health outcomes as well.

Methods used

The majority of the evaluations reported quantitative (13) or mixed methods (9), but three services were evaluated using qualitative methods alone. Three of the studies were trials, while three were action research studies, one of which was within a mixed methods evaluation. Most collected data on structure, process and outcomes (13) or structure and process (5) (see Table 2).

The most common methods were extracting data from referral forms (10), costings of the service (9), patient satisfaction questionnaires (9) and patient health status questionnaires (8). The majority of patient satisfaction questionnaires were designed specifically for the evaluation, the exception being the Picker Institute questionnaire in the Tzu Chi¹⁹ study. Likewise, all patient health status questionnaires were designed locally.

In terms of health outcomes, some studies relied on locally developed self-reports (either retrospective or before and after) but many used validated

health outcome measures such as the SF36 (6) or MYMOP (5). Qualitative data tended to be interviews with therapists (5) or focus groups with users or NHS staff (5) (see Table 3).

Rating of the evaluations against the modified BESTCAM checklist

In terms of assessing the evaluations against BESTCAM, the reports are ranked in order from the highest to the lowest in Table 2. Using the crude

Table 3 Specific details of methods

Method used	Number of reports citing this source
Data extraction of referral forms	10
Costings of service	9
Survey of users (patient satisfaction)	9
Survey of users (health status)	8
Data extraction of medical records	7
SF36	6
Interviews with therapists	5
Focus group	5
MYMOP	5
Costings of savings made	5
Survey of GPs	5
Interviews with users	4
Case studies	4
Interviews with NHS staff	4
Survey of therapists	4
Hospital Anxiety and Depression Scale	2
Pain Index	2
Questionnaire to therapists	2
Data extraction of therapists' case notes	2
SF12	1
Inventory of Personal Problems	1
Beck's Depression Scale	1
Functions Limitations Profile	1
Survey of NHS staff	1
Nottingham Health Profile	1
Patient Generated Index	1
GP satisfaction survey	1
Glasgow Homeopathic Hospital Outcomes Scale	1
Data extraction of patient monitoring form (pre-post)	1
Short form McGill Pain Questionnaire	1
EuroQol CEQ-5D	1
Extended Aberdeen Spine Pain Scale	1

Total exceeds 32 as more than one method per report.

measure of 'points out of 27', Glastonbury¹⁵ (25), Newcastle²⁷ (21), West Yorkshire³² (18) and North Kirklees³¹ (17) top the list. The first three scored highly because their studies focused on NHS costs, including data on impact on GP consultation time, prescription rates and/or secondary care referrals. Authors for two of the three reports (Newcastle²⁷ and West Yorkshire³²) were based in commissioning agencies.

In addressing costs, financial information tended to be costings of the service (9) although five also included data on estimated savings made and one trial included a full cost utility economic study. Five evaluations included data on prescription rates and savings in GP consultation time; three incorporated secondary care referral data (consultant, tests or in-patient days) and one reported reductions in time off sick.

Numbers of reports available to explore link between evaluation and funding decisions

Information about the relationship between evaluations and funding is missing for several services (either known or suspected as discontinued) operating in the 1990s (Rydings Hall,¹² West Yorkshire,³² GP based purchasing,²⁰ Sydenham,⁵ Phoenix,²² Leyton Green⁶). Thirteen of the 25 services (Glastonbury,¹⁵ Newcastle,²⁷ Liverpool,¹⁷ Sheffield Menopause Clinic,²⁸ CHI,¹⁸ CHIPS,⁷⁻⁹ Helios,²⁶ Get Well UK,³⁵ St. Margarets,¹¹ Cullompton,¹³ ROMANS,^{33,34} CHOICE,³⁶ Marylebone²¹) still operate. However, not all of their evaluations are useful in exploring the link between evaluations and funding. The Get Well UK,³⁵ CHI¹⁸ and CHOICE³⁶ reports are interim evaluations. The Marylebone²¹ report is a partial evaluation with a full report remaining unobtainable. The Helios²⁶ evaluation was part of a wider review of seven anthroposophical practices across the country. Full information on the Cullompton¹³ practice is not known, however (at the time of writing) spiritual healing is offered for free at this practice. In total, we could not explore the relationship between evaluations and funding for 12 of the 25 services.

Characteristics of successful and unsuccessful evaluations aiming for state funding

However, we do have sufficient information from 13 others. Of those 13, six evaluations explicitly aimed to persuade state funders. Of those six, three were successful, but not all in the first instance. An aspect that two of the successful

reports (Newcastle²⁷ and St. Margarets¹¹) have in common is that they took prime commissioning drivers of prescription costs and GP consultation times, extracted data from medical records, calculated the savings made for their sample population and then extrapolated the savings across to all patients in the service. So, there are statements like "Outpatient saving 35 patients $\times 77 = \pounds 2695$ annual saving"¹¹ which are then totalled. In the St. Margaret's¹¹ report they put these key points into eye-catching, highlighted boxes. Both reports are also short (less than 20 pages) with generous white space on the page making them easily readable.

The strategy of catering to a commissioning audience is not always immediately successful, however. The Glastonbury¹⁵ report, which took into account prescription rates, secondary referrals, GP consultation time and directly costed the savings made as a result of the service, did not lead to immediate NHS funding. Although this evaluation did include data of interest to NHS commissioners, unlike the St. Margarets¹¹ and Newcastle²⁷ reports it was not written in a "funder friendly" format as the report is over 30 pages long with dense type. In the long term, the practice was able to win funding from the NHS for a musculo-skeletal service using acupuncture and osteopathy but other therapies at the centre depend on donations.

Three of the six evaluations aiming for further funding did not win their bids (Lewisham,²³⁻²⁵ Tzu Chi¹⁹ and North Kirklees³¹). The first two evaluations concentrated on providing convincing health status data using the SF36, one (Lewisham) through a randomized controlled trial with waiting list controls ($n = 762$) and the other (Tzu Chi) through a survey ($n = 320$). North Kirklees also provided health outcomes data (through MYMOP) as well as views on the service from GPs and users. All three reports included data on service costs, but not on prescription or GP consultation rates.

Other factors in successful evaluations

Over and above the actual methodologies of the papers, who is involved in writing and presenting them may be an influential factor. In looking at successful (or ultimately successful) evaluations, the Newcastle²⁷ report was co-written by a NHS pharmaceutical advisor and the St. Margarets¹¹ and Glastonbury¹⁵ reports were co-authored by GPs. The Lewisham,²³⁻²⁵ North Kirklees³¹ and Tzu Chi¹⁹ reports were written by the service providers on their own or with academics without assistance from professionals within the state funded health systems.

The rest of the evaluations for which we have information on the relationship between evaluations and funding

In teasing out the role that evaluations may play in funding decisions, seven evaluations fall into a complicated group. In two cases, both regeneration projects (CHIPS⁷⁻⁹ and Hartcliffe and Withywood¹⁴), the key evaluation aim was not to influence NHS commissioners but rather report to community-based funders. Subsequently, the CHIPS service did present their evaluation report for consideration by the local Primary Care Trust (PCT) but were turned down because (among other reasons) they did not include cost pressure data.

For three other services (Sheffield Menopause Clinic,²⁸ Liverpool,¹⁷ ROMANS^{33,34}), all of which continue to be NHS funded, the decision seems to have been largely made before evaluation results were known. Subsequently, the evaluations have bolstered the case for continued contracts, but were not crucial in making initial decisions.

For two services (Bounds Green³⁰ and Coventry²⁹) the reports acknowledge that despite favourable results, NHS commissioners decided not to fund the service. Interestingly, the aim of the Coventry evaluation was identified as

Inform[ing] future commissioning decisions about homeopathy services in Coventry²⁹

However despite glowing results including favourable data on health outcomes, GP consultation rates and prescription costs, the service was discontinued "due to limited funding".²⁹ This suggests that despite providing a range of persuasive, commissioner targeted data in a report authored by two PCT managers and a GP, factors other than the evaluation may have had greater bearing.

Discussion

Using the structure, process and outcome model in addition to the Delphi criteria worked well in identifying the content of the reports and their ability to address NHS funding concerns. But like any tools there were shortcomings, particularly with the Delphi criteria in that they did not take into account the robustness of the data. Many methodological issues such as inadequate sample sizes, selection bias and insufficient analysis of qualitative data affected these reports.

For example with prescription rates, the Leyton Green⁶ evaluations take before and after data

directly from medical records for all patients seen over a specified 6 months of the service. The St. Margaret's¹¹ evaluation sample data (we are not told on what basis) for only 10% of their cases and access before and after data from medical notes, while in the Rydings Hall¹² evaluation patients are asked after treatment "Have you stopped medication for the condition you were referred since starting homoeopathic treatment?" In terms of trustworthiness of data, those of the Leyton Green⁶ evaluation are the most robust, while the other two are open to bias, yet all meet the criteria of addressing prescription rates in their report. As such, the Delphi criteria are limited in their usefulness of providing an indication of report quality.

This brings up questions about the importance of "good quality" evaluations in commissioning decisions. Although assessing the quality of such a broad spectrum of documents is problematic, plainly certain reports were of a higher calibre than others. Nonetheless it would be spurious to suggest that the better quality evaluations scored more highly on BESTCAM guidelines or were more likely to be funded as this was not always the case.

A limitation of this study is that the relationship between evaluations and NHS funding decisions can only be explored for just over half of the 25 services. From the information we do have though, it appears the relationship between the two is tenuous at best.

Rarely do health outcome data on their own sway NHS funders. Inclusion of secondary care referrals, prescription and GP consultation rates can strengthen the case. In addition, writing short, readable reports that focus on savings made (ideally co-written with a commissioning manager or GP) may be even more persuasive. But it is entirely conceivable that even evaluations with all those ingredients may not be successful.

Furthermore, the role that evaluations play in funding decisions appears even shakier in that sometimes decisions to fund a service have been made before evaluation results are known. This suggests that evaluations, although a potentially useful tool, are only one of many strands in mounting a successful strategy for NHS funding of complementary therapy services in primary and community care.

Competing interests

The first author is a kinesiologist and the last author is a GP. This study was presented in abbreviated form as a poster at the 2004 Exeter conference.

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